April 6, 2007

ENGROSSED
SENATE BILL No. 503

DIGEST OF SB 503 (Updated April 4, 2007 8:16 pm - DI 77)

Citations Affected: IC 4-22; IC 5-10; IC 6-3.1; IC 12-7; IC 12-15; IC 12-16; IC 12-17.6; IC 16-18; IC 16-45; IC 20-26; IC 27-8; IC 27-13; noncode.

Synopsis: Health coverage. Provides for a tax credit related to employee wellness programs. Increases the income limit for Medicaid eligibility for pregnant women. Provides for 12 continuous months of eligibility for an eligible child under Medicaid or the children's health insurance program (CHIP). Requires that the office of Medicaid policy and planning (OMPP) require a foster care Medicaid recipient to participate in the risk-based managed care program. Establishes the healthier Indiana insurance program and the healthier Indiana insurance trust fund. Allows OMPP to develop: (1) a premium

(Continued next page)

Effective: Upon passage; July 1, 2007.

Miller, Simpson, Becker, Errington, Sipes, Rogers, Riegsecker

(HOUSE SPONSORS — BROWN C, BROWN T, FRY, ORENTLICHER)

January 23, 2007, read first time and referred to Committee on Health and Provider Services.
February 8, 2007, amended, reported favorably — Do Pass; reassigned to Committee on Appropriations.
February 15, 2007, amended, reported favorably — Do Pass.
February 19, 2007, read second time, amended, ordered engrossed.
February 20, 2007, engrossed. Read third time, passed. Yeas 46, nays 1.

HOUSE ACTION

March 13, 2007, read first time and referred to Committee on Public Health.
April 5, 2007, amended, reported — Do Pass.

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Digest Continued

assistance program; and (2) subject to approval and funding, a health care account program for individuals who have an annual income of not more than 300% of the federal poverty level. Provides that OMPP may not enroll applicants, approve any contracts to provide services or administer the program, incur costs other than those necessary to study and plan for the program, or create financial obligations for the state unless: (1) there is a specific appropriation from the general assembly to implement the program; and (2) after review by the budget committee, the budget agency approves an actuarial analysis that determines sufficient funding is reasonably estimated to be available to operate the program for at least the following eight years. Makes funding changes to the hospital care for the indigent program, the municipal disproportionate share program, and the Medicaid indigent care trust fund. Requires the Indiana comprehensive health insurance association to provide, and referred program participants to participate in, medical management services. Increases the CHIP eligibility family income limit. Establishes the rural health care pilot program. Provides private health insurers and health maintenance organizations to cover children up to 24 years old upon request. Requires application for necessary federal Medicaid approval, including presumptive eligibility for certain pregnant women. Makes an appropriation. Requires OMPP to apply to the United States Department of Health and Human Services for a demonstration waiver to develop and implement the healthier Indiana insurance program. Makes conforming and technical changes.

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April 6, 2007

First Regular Session 115th General Assembly (2007)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2006 Regular Session of the General Assembly.

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ENGROSSED
SENATE BILL No. 503

A BILL FOR AN ACT to amend the Indiana Code concerning coverage of health care and to make an appropriation.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 4-22-2-37.1, AS AMENDED BY P.L.47-2006, SECTION 2, AS AMENDED BY P.L.91-2006, SECTION 2, AND AS AMENDED BY P.L.123-2006, SECTION 12, IS CORRECTED AND AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 37.1. (a) This section applies to a rulemaking action resulting in any of the following rules:

(1) An order adopted by the commissioner of the Indiana department of transportation under IC 9-20-1-3(d) or IC 9-21-4-7(a) and designated by the commissioner as an emergency rule.

(2) An action taken by the director of the department of natural resources under IC 14-22-2-6(d) or IC 14-22-6-13.

(3) An emergency temporary standard adopted by the occupational safety standards commission under IC 22-8-1.1-16.1.

(4) An emergency rule adopted by the solid waste management board under IC 13-22-2-3 and classifying a waste as hazardous.

(5) A rule, other than a rule described in subdivision (6), adopted by the department of financial institutions under IC 24-4.5-6-107 and declared necessary to meet an emergency.

(6) A rule required under IC 24-4.5-1-106 that is adopted by the department of financial institutions and declared necessary to meet an emergency under IC 24-4.5-6-107.

(7) A rule adopted by the Indiana utility regulatory commission to address an emergency under IC 8-1-2-113.

(8) An emergency rule adopted by the state lottery commission under IC 4-30-3-9.

(9) A rule adopted under IC 16-19-3-5 that the executive board of the state department of health declares is necessary to meet an emergency.

(10) An emergency rule adopted by the Indiana finance authority under IC 8-21-12.

(11) An emergency rule adopted by the insurance commissioner under IC 27-1-23-7.

(12) An emergency rule adopted by the Indiana horse racing commission under IC 4-31-3-9.

(13) An emergency rule adopted by the air pollution control board, the solid waste management board, or the water pollution control board under IC 13-15-4-10(4) or to comply with a deadline required by federal law, provided:

(A) the variance procedures are included in the rules; and

(B) permits or licenses granted during the period the emergency rule is in effect are reviewed after the emergency rule expires.

(14) An emergency rule adopted by the Indiana election commission under IC 3-6-4.1-14.

(15) An emergency rule adopted by the department of natural resources under IC 14-10-2-5.

(16) An emergency rule adopted by the Indiana gaming commission under *IC 4-32.2-3-3(b),* IC 4-33-4-2, IC 4-33-4-3, or IC 4-33-4-14.

(17) An emergency rule adopted by the alcohol and tobacco commission under IC 7.1-3-17.5, IC 7.1-3-17.7, or IC 7.1-3-20-24.4.

(18) An emergency rule adopted by the department of financial institutions under IC 28-15-11.

(19) An emergency rule adopted by the office of the secretary of family and social services under IC 12-8-1-12.

(20) An emergency rule adopted by the office of the children's

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health insurance program under IC 12-17.6-2-11.

(21) An emergency rule adopted by the office of Medicaid policy and planning under IC 12-15-41-15 **or IC 12-15-44-16.**

(22) An emergency rule adopted by the Indiana state board of animal health under IC 15-2.1-18-21.

(23) An emergency rule adopted by the board of directors of the Indiana education savings authority under IC 21-9-4-7.

(24) An emergency rule adopted by the Indiana board of tax review under IC 6-1.1-4-34 **(repealed).**

(25) An emergency rule adopted by the department of local government finance under IC 6-1.1-4-33 **(repealed).**

(26) An emergency rule adopted by the boiler and pressure vessel rules board under IC 22-13-2-8(c).

(27) An emergency rule adopted by the Indiana board of tax review under IC 6-1.1-4-37(l) **(repealed)** or an emergency rule adopted by the department of local government finance under IC 6-1.1-4-36(j) **(repealed)** or IC 6-1.1-22.5-20.

(28) An emergency rule adopted by the board of the Indiana economic development corporation under IC 5-28-5-8.

(29) A rule adopted by the department of financial institutions under IC 34-55-10-2.5.

(30) A rule adopted by the Indiana finance authority:

(A) under IC 8-15.5-7 approving user fees (as defined in IC 8-15.5-2-10) provided for in a public-private agreement under IC 8-15.5;

(B) under IC 8-15-2-17.2(a)(10):

(i) establishing enforcement procedures; and

(ii) making assessments for failure to pay required tolls;

(C) under IC 8-15-2-14(a)(3) authorizing the use of and establishing procedures for the implementation of the collection of user fees by electronic or other nonmanual means; or

(D) to make other changes to existing rules related to a toll road project to accommodate the provisions of a public-private agreement under IC 8-15.5.

(b) The following do not apply to rules described in subsection (a):

(1) Sections 24 through 36 of this chapter.

(2) IC 13-14-9.

(c) After a rule described in subsection (a) has been adopted by the agency, the agency shall submit the rule to the publisher for the assignment of a document control number. The agency shall submit the rule in the form required by section 20 of this chapter and with the

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documents required by section 21 of this chapter. The publisher shall determine the ~~number of copies~~ *format* of the rule and other documents to be submitted under this subsection.

(d) After the document control number has been assigned, the agency shall submit the rule to the ~~secretary of state~~ *publisher* for filing. The agency shall submit the rule in the form required by section 20 of this chapter and with the documents required by section 21 of this chapter. The ~~secretary of state~~ *publisher* shall determine the ~~number of copies~~ *format* of the rule and other documents to be submitted under this subsection.

(e) Subject to section 39 of this chapter, the ~~secretary of state~~ *publisher* shall:

(1) accept the rule for filing; and

(2) ~~file stamp and indicate~~ *electronically record* the date and time that the rule is accepted. ~~on every duplicate original copy submitted.~~

(f) A rule described in subsection (a) takes effect on the latest of the following dates:

(1) The effective date of the statute delegating authority to the agency to adopt the rule.

(2) The date and time that the rule is accepted for filing under subsection (e).

(3) The effective date stated by the adopting agency in the rule.

(4) The date of compliance with every requirement established by law as a prerequisite to the adoption or effectiveness of the rule.

(g) Subject to subsection (h), IC 14-10-2-5, IC 14-22-2-6, IC 22-8-1.1-16.1, and IC 22-13-2-8(c), and except as provided in subsections (j), ~~and~~ (k), *and (l),* a rule adopted under this section expires not later than ninety (90) days after the rule is accepted for filing under subsection (e). Except for a rule adopted under subsection (a)(13), (a)(24), (a)(25), or (a)(27), the rule may be extended by adopting another rule under this section, but only for one (1) extension period. The extension period for a rule adopted under subsection (a)(28) may not exceed the period for which the original rule was in effect. A rule adopted under subsection (a)(13) may be extended for two (2) extension periods. Subject to subsection (j), a rule adopted under subsection (a)(24), (a)(25), or (a)(27) may be extended for an unlimited number of extension periods. Except for a rule adopted under subsection (a)(13), for a rule adopted under this section to be effective after one (1) extension period, the rule must be adopted under:

(1) sections 24 through 36 of this chapter; or

(2) IC 13-14-9;

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as applicable.

(h) A rule described in subsection (a)(6), (a)(8), (a)(12), or (a)(29) expires on the earlier of the following dates:

(1) The expiration date stated by the adopting agency in the rule.

(2) The date that the rule is amended or repealed by a later rule adopted under sections 24 through 36 of this chapter or this section.

(i) This section may not be used to readopt a rule under IC 4-22-2.5.

(j) A rule described in subsection (a)(24) or (a)(25) expires not later than January 1, 2006.

(k) A rule described in subsection (a)(28) expires on the expiration date stated by the board of the Indiana economic development corporation in the rule.

(l) A rule described in subsection (a)(30) expires on the expiration date stated by the Indiana finance authority in the rule.

SECTION 2. IC 5-10-8-2.2, AS AMENDED BY P.L.2-2005, SECTION 15, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2.2. (a) As used in this section, "dependent" means a natural child, stepchild, or adopted child of a public safety employee who:

(1) is less than eighteen (18) years of age;

(2) is eighteen (18) years of age or older and physically or mentally disabled (using disability guidelines established by the Social Security Administration); or

(3) is at least eighteen (18) and less than twenty-three (23) years of age and is enrolled in and regularly attending a secondary school or is a full-time student at an accredited college or university.

(b) As used in this section, "public safety employee" means a full-time firefighter, police officer, county police officer, or sheriff.

(c) This section applies only to local unit public employers and their public safety employees.

(d) A local unit public employer may provide programs of group health insurance for its active and retired public safety employees through one (1) of the following methods:

(1) By purchasing policies of group insurance.

(2) By establishing self-insurance programs.

(3) By electing to participate in the local unit group of local units that offer the state employee health plan under section 6.6 of this chapter.

(4) By electing to participate in a state employee health plan under section 6.7 of this chapter.

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A local unit public employer may provide programs of group insurance other than group health insurance for the local unit public employer's active and retired public safety employees by purchasing policies of group insurance and by establishing self-insurance programs. However, the establishment of a self-insurance program is subject to the approval of the unit's fiscal body.

(e) A local unit public employer may pay a part of the cost of group insurance for its active and retired public safety employees. However, a local unit public employer that provides group life insurance for its active and retired public safety employees shall pay a part of the cost of that insurance.

(f) A local unit public employer may not cancel an insurance contract under this section during the policy term of the contract.

(g) After June 30, 1989, a local unit public employer that provides a group health insurance program for its active public safety employees shall also provide a group health insurance program to the following persons:

(1) Retired public safety employees.

(2) Public safety employees who are receiving disability benefits under IC 36-8-6, IC 36-8-7, IC 36-8-7.5, IC 36-8-8, or IC 36-8-10.

(3) Surviving spouses and dependents of public safety employees who die while in active service or after retirement.

(h) A retired or disabled public safety employee who is eligible for group health insurance coverage under subsection (g)(1) or (g)(2):

(1) may elect to have the person's spouse, dependents, or spouse and dependents covered under the group health insurance program at the time the person retires or becomes disabled;

(2) must file a written request for insurance coverage with the employer within ninety (90) days after the person retires or begins receiving disability benefits; and

(3) must pay an amount equal to the total of the employer's and the employee's premiums for the group health insurance for an active public safety employee (however, the employer may elect to pay any part of the person's premiums).

(i) Except as provided in IC 36-8-6-9.7(f), IC 36-8-6-10.1(h), IC 36-8-7-12.3(g), IC 36-8-7-12.4(j), IC 36-8-7.5-13.7(h), IC 36-8-7.5-14.1(i), IC 36-8-8-13.9(d), IC 36-8-8-14.1(h), and IC 36-8-10-16.5 for a surviving spouse or dependent of a public safety employee who dies in the line of duty, a surviving spouse or dependent who is eligible for group health insurance under subsection (g)(3):

(1) may elect to continue coverage under the group health insurance program after the death of the public safety employee;

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(2) must file a written request for insurance coverage with the employer within ninety (90) days after the death of the public safety employee; and

(3) must pay the amount that the public safety employee would have been required to pay under this section for coverage selected by the surviving spouse or dependent (however, the employer may elect to pay any part of the surviving spouse's or dependents' premiums).

(j) A retired or disabled public safety employee's eligibility for group health insurance under this section ends on the earlier of the following:

(1) When the public safety employee becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.

(2) When the employer terminates the health insurance program for active public safety employees.

(k) A surviving spouse's eligibility for group health insurance under this section ends on the earliest of the following:

(1) When the surviving spouse becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.

(2) When the unit providing the insurance terminates the health insurance program for active public safety employees.

(3) The date of the surviving spouse's remarriage.

(4) When health insurance becomes available to the surviving spouse through employment.

(l) A dependent's eligibility for group health insurance under this section ends on the earliest of the following:

(1) When the dependent becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.

(2) When the unit providing the insurance terminates the health insurance program for active public safety employees.

(3) When the dependent no longer meets the criteria set forth in subsection (a).

(4) When health insurance becomes available to the dependent through employment.

(m) A public safety employee who is on leave without pay is entitled to participate for ninety (90) days in any group health insurance program maintained by the local unit public employer for active public safety employees if the public safety employee pays an amount equal to the total of the employer's and the employee's premiums for the insurance. However, the employer may pay all or part of the employer's premium for the insurance.

(n) A local unit public employer may provide group health

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insurance for retired public safety employees or their spouses not covered by subsections (g) through (l) and may provide group health insurance that contains provisions more favorable to retired public safety employees and their spouses than required by subsections (g) through (l). A local unit public employer may provide group health insurance to a public safety employee who is on leave without pay for a longer period than required by subsection (m), and may continue to pay all or a part of the employer's premium for the insurance while the employee is on leave without pay.

SECTION 3. IC 5-10-8-2.6, AS AMENDED BY P.L.1-2005, SECTION 76, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2.6. (a) This section applies only to local unit public employers and their employees. This section does not apply to public safety employees, surviving spouses, and dependents covered by section 2.2 of this chapter.

(b) A public employer may provide programs of group insurance for its employees and retired employees. The public employer may, however, exclude part-time employees and persons who provide services to the unit under contract from any group insurance coverage that the public employer provides to the employer's full-time employees. A public employer may provide programs of group health insurance under this section through one (1) of the following methods:

(1) By purchasing policies of group insurance.

(2) By establishing self-insurance programs.

(3) By electing to participate in the local unit group of local units that offer the state employee health plan under section 6.6 of this chapter.

(4) By electing to participate in a state employee health plan under section 6.7 of this chapter.

A public employer may provide programs of group insurance other than group health insurance under this section by purchasing policies of group insurance and by establishing self-insurance programs. However, the establishment of a self-insurance program is subject to the approval of the unit's fiscal body.

(c) A public employer may pay a part of the cost of group insurance, but shall pay a part of the cost of group life insurance for local employees. A public employer may pay, as supplemental wages, an amount equal to the deductible portion of group health insurance as long as payment of the supplemental wages will not result in the payment of the total cost of the insurance by the public employer.

(d) An insurance contract for local employees under this section may not be canceled by the public employer during the policy term of

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the contract.

(e) After June 30, 1986, a public employer shall provide a group health insurance program under subsection (g) to each retired employee:

(1) whose retirement date is:

(A) after May 31, 1986, for a retired employee who was a teacher (as defined in IC 20-18-2-22) for a school corporation; or

(B) after June 30, 1986, for a retired employee not covered by clause (A);

(2) who will have reached fifty-five (55) years of age on or before the employee's retirement date but who will not be eligible on that date for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.;

(3) who will have completed twenty (20) years of creditable employment with a public employer on or before the employee's retirement date, ten (10) years of which must have been completed immediately preceding the retirement date; and

(4) who will have completed at least fifteen (15) years of participation in the retirement plan of which the employee is a member on or before the employee's retirement date.

(f) A group health insurance program required by subsection (e) must be equal in coverage to that offered active employees and must permit the retired employee to participate if the retired employee pays an amount equal to the total of the employer's and the employee's premiums for the group health insurance for an active employee and if the employee, within ninety (90) days after the employee's retirement date files a written request with the employer for insurance coverage. However, the employer may elect to pay any part of the retired employee's premiums.

(g) A retired employee's eligibility to continue insurance under subsection (e) ends when the employee becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq., or when the employer terminates the health insurance program. A retired employee who is eligible for insurance coverage under subsection (e) may elect to have the employee's spouse covered under the health insurance program at the time the employee retires. If a retired employee's spouse pays the amount the retired employee would have been required to pay for coverage selected by the spouse, the spouse's subsequent eligibility to continue insurance under this section is not affected by the death of the retired employee. The surviving spouse's eligibility ends on the earliest of the following:

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(1) When the spouse becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.

(2) When the employer terminates the health insurance program.

(3) Two (2) years after the date of the employee's death.

(4) The date of the spouse's remarriage.

(h) This subsection does not apply to an employee who is entitled to group insurance coverage under IC 20-28-10-2(b). An employee who is on leave without pay is entitled to participate for ninety (90) days in any group health insurance program maintained by the public employer for active employees if the employee pays an amount equal to the total of the employer's and the employee's premiums for the insurance. However, the employer may pay all or part of the employer's premium for the insurance.

(i) A public employer may provide group health insurance for retired employees or their spouses not covered by subsections (e) through (g) and may provide group health insurance that contains provisions more favorable to retired employees and their spouses than required by subsections (e) through (g). A public employer may provide group health insurance to an employee who is on leave without pay for a longer period than required by subsection (h), and may continue to pay all or a part of the employer's premium for the insurance while the employee is on leave without pay.

SECTION 4. IC 5-10-8-6.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 6.7. (a) As used in this section, "state employee health plan" means:**

(1) a self-insurance program established under section 7(b) of this chapter to provide group health coverage; or

(2) a contract with a prepaid health care delivery plan entered into by the state personnel department under section 7(c) of this chapter.

(b) The state personnel department shall allow a local unit to provide coverage of health care services for employees of the local unit through any state employee health plan available to state employees.

(c) If a local unit provides health coverage for employees or retired employees of the local unit, the local unit may elect to provide the health coverage, and the state personnel department shall allow the local unit to provide the health coverage:

(1) through a state employee health plan as provided in this section; and

(2) as described in section 2.2 or 2.6 of this chapter, whichever

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is applicable to the employees or retired employees of the local unit for whom health coverage is being provided.

(d) A local unit employee who receives coverage of health care services under a state employee health plan under subsection (c) must:

(1) receive coverage equal to the coverage provided to state employees under the state employee health plan; and

(2) be allowed to choose the state employee health plan under which the local unit employee will be covered.

(e) The total premium rate that is charged to a local unit for coverage of an employee of the local unit under a state employee health plan under this section must be the same total premium rate that is charged to the state for the same coverage for an employee of the state.

SECTION 5. IC 5-10-8-6.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 6.8. (a) As used in this section, "small employer" means a private employer, including a nonprofit organization, that employs at least two (2) but not more than fifty (50) full-time employees.**

(b) As used in this section, "state employee health plan" means:

(1) a self-insurance program established under section 7(b) of this chapter to provide group health coverage; or

(2) a contract with a prepaid health care delivery plan entered into by the state personnel department under section 7(c) of this chapter.

(c) The state personnel department shall allow a small employer to provide coverage of health care services for employees of the small employer under any state employee health plan available to state employees.

(d) IC 27-8-15 does not apply to coverage provided to employees of a small employer under this section.

(e) A small employer's employee who receives coverage of health care services under a state employee health plan under subsection (c) must:

(1) receive coverage equal to the coverage provided to state employees under the state employee health plan; and

(2) be allowed to choose the state employee health plan under which the employee will be covered.

(f) The total premium rate that is charged to a small employer for coverage of an employee of the small employer under a state employee health plan under this section must be the same total

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premium rate that is charged to the state for the same coverage for an employee of the state.

SECTION 6. IC 6-3.1-31 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]:

Chapter 31. Employee Wellness Program Tax Credit

Sec. 1. As used in this chapter, "pass through entity" means:

(1) a corporation that is exempt from the adjusted gross income tax under IC 6-3-2-2.8(2);

(2) a partnership;

(3) a limited liability company; or

(4) a limited liability partnership.

Sec. 2. As used in this chapter, "state tax liability" means a taxpayer's total tax liability that is incurred under:

(1) IC 6-3-1 through IC 6-3-7 (the adjusted gross income tax);

(2) IC 6-5.5 (the financial institutions tax); and

(3) IC 27-1-18-2 (the insurance premiums tax);

as computed after the application of the credits that under IC 6-3.1-1-2 are to be applied before the credit provided by this chapter.

Sec. 3. As used in this chapter, "taxpayer" means an individual or entity that has any state tax liability.

Sec. 4. As used in this chapter, "wellness program" means a program that rewards:

(1) overweight employees for losing weight and all employees for maintaining a healthy weight; or

(2) employees for not using tobacco.

Sec. 5. A taxpayer is entitled to a credit against the taxpayer's state tax liability for a taxable year in an amount equal to fifty percent (50%) of the costs incurred by the taxpayer during the taxable year for providing a wellness program for the taxpayer's employees during the taxable year.

Sec. 6. If a pass through entity is entitled to a credit under section 5 of this chapter but does not have state tax liability against which the tax credit may be applied, a shareholder, partner, or member of the pass through entity is entitled to a tax credit equal to:

(1) the tax credit determined for the pass through entity for the taxable year; multiplied by

(2) the percentage of the pass through entity's distributive income to which the shareholder, partner, or member is entitled.

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Sec. 7. (a) If the credit provided by this chapter exceeds the taxpayer's state tax liability for the taxable year for which the credit is first claimed, the excess may be carried forward to succeeding taxable years and used as a credit against the taxpayer's state tax liability during those taxable years. Each time that the credit is carried forward to a succeeding taxable year, the credit is to be reduced by the amount that was used as a credit during the immediately preceding taxable year.

(b) A taxpayer is not entitled to any carryback or refund of any unused credit.

Sec. 8. To receive the credit provided by this chapter, a taxpayer must claim the credit on the taxpayer's state tax return or returns in the manner prescribed by the department. The taxpayer shall submit to the department all information that the department determines is necessary for the calculation of the credit provided by this chapter.

SECTION 7. IC 12-7-2-52.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 52.5. "Custodial parent", for purposes of IC 12-15-44, has the meaning set forth in IC 12-15-44-1.**

SECTION 8. IC 12-7-2-144.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 144.3. "Preventative care services", for purposes of IC 12-15-44, has the meaning set forth in IC 12-15-44-2.**

SECTION 9. IC 12-7-2-146 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 146. "Program" refers to the following:

(1) For purposes of IC 12-10-7, the adult guardianship services program established by IC 12-10-7-5.

(2) For purposes of IC 12-10-10, the meaning set forth in IC 12-10-10-5.

(3) For purposes of IC 12-17.6, the meaning set forth in IC 12-17.6-1-5.

(4) For purposes of IC 12-15-44, the meaning set forth in IC 12-15-44-3.

SECTION 10. IC 12-15-2-13 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 13. (a) A pregnant woman:

(1) who is not described in 42 U.S.C. 1396a(a)(10)(A)(i); and

(2) whose family income does not exceed the income level established in subsection (b);

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is eligible to receive Medicaid.

(b) A pregnant woman described in this section is eligible to receive Medicaid, subject to subsections (c) and (d) and 42 U.S.C. 1396a et seq., if her family income does not exceed ~~one~~ **two** hundred ~~fifty~~ percent ~~(150%)~~ **(200%)** of the federal income poverty level for the same size family.

(c) Medicaid made available to a pregnant woman described in this section is limited to medical assistance for services related to pregnancy, including prenatal, delivery, and postpartum services, and to other conditions that may complicate pregnancy.

(d) Medicaid is available to a pregnant woman described in this section for the duration of the pregnancy and for the sixty (60) day postpartum period that begins on the last day of the pregnancy, without regard to any change in income of the family of which she is a member during that time.

(e) The office may apply a resource standard in determining the eligibility of a pregnant woman described in this section.

SECTION 11. IC 12-15-2-15.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 15.8. An individual who is less than nineteen (19) years of age and who is eligible for Medicaid under section 14 of this chapter is eligible to receive Medicaid until the earlier of the following:**

(1) The end of a period of twelve (12) consecutive months following a determination of the individual's eligibility for Medicaid.

(2) The individual becomes nineteen (19) years of age.

SECTION 12. IC 12-15-12-14.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 14.5. (a) This section applies to a foster care child who is less than eighteen (18) years of age, is not disabled, and is a Medicaid recipient.**

(b) Not later than January 1, 2008, the office shall require a Medicaid recipient described in subsection (a) to enroll in the risk-based managed care program.

(c) The office:

(1) shall apply to the United States Department of Health and Human Services for any approval necessary; and

(2) may adopt rules under IC 4-22-2;

to implement this section.

SECTION 13. IC 12-15-15-1.1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1.1. (a) This section

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applies to a hospital that is:

(1) licensed under IC 16-21; and

(2) established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23.

(b) For a state fiscal year ending after June 30, 2003, in addition to reimbursement received under section 1 of this chapter, a hospital is entitled to reimbursement in an amount calculated as follows:

STEP ONE: The office shall identify the aggregate inpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by hospitals established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23.

STEP TWO: For the aggregate inpatient hospital services identified under STEP ONE, the office shall calculate the aggregate payments made under this article and under the state Medicaid plan to hospitals established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the amount that would have been paid in the aggregate by the office for the inpatient hospital services described in STEP ONE under Medicare payment principles.

STEP FOUR: Subtract the amount calculated under STEP TWO from the amount calculated under STEP THREE.

STEP FIVE: Subject to subsection (g), from the amount calculated under STEP FOUR, allocate to a hospital established and operated under IC 16-22-8 an amount equal to one hundred percent (100%) of the difference between:

(A) the total cost for the hospital's provision of inpatient services covered under this article for the hospital's fiscal year ending during the state fiscal year; and

(B) the total payment to the hospital for its provision of inpatient services covered under this article for the hospital's fiscal year ending during the state fiscal year, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP SIX: Subtract the amount calculated under STEP FIVE from the amount calculated under STEP FOUR.

STEP SEVEN: Distribute an amount equal to the amount calculated under STEP SIX to the eligible hospitals established and operated under IC 16-22-2 or IC 16-23 described in subsection (c) in proportion to each hospital's Medicaid ~~shortfall~~ **supplemental payment** as defined in subsection (f).

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(c) Subject to subsection (e), reimbursement for a state fiscal year under this section consists of payments made after the close of each state fiscal year. ~~Payment for a state fiscal year ending after June 30, 2003, shall be made before December 31 following the state fiscal year's end.~~ A hospital is not eligible for a payment described in this subsection unless an intergovernmental transfer is made under subsection (d).

(d) Subject to subsection (e), a hospital may make an intergovernmental transfer under this subsection, or an intergovernmental transfer may be made on behalf of the hospital, after the close of each state fiscal year. An intergovernmental transfer under this subsection must be made to the Medicaid indigent care trust fund in an amount equal to a percentage, as determined by the office, of the amount to be distributed to the hospital under ~~STEP SEVEN of subsection (b). In determining the percentage, the office shall apply the same percentage of not more than eighty-five percent (85%) to all hospitals eligible for reimbursement under STEP SEVEN of subsection (b).~~ **this section.** The office shall use the intergovernmental transfer to fund payments made under this section. ~~and as otherwise provided under IC 12-15-20-2(8).~~

(e) A hospital making an intergovernmental transfer under ~~subsection (d)~~ **this section** may appeal under IC 4-21.5 the amount determined by the office to be paid the hospital under ~~STEP SEVEN of~~ subsection (b). The periods described in subsections (c) and (d) for the hospital to make an intergovernmental transfer are tolled pending the administrative appeal and any judicial review initiated by the hospital under IC 4-21.5. The distribution to other hospitals under ~~STEP SEVEN of~~ subsection (b) may not be delayed due to an administrative appeal or judicial review instituted by a hospital under this subsection. If necessary, the office may make a partial distribution to the other eligible hospitals under ~~STEP SEVEN of~~ subsection (b) pending the completion of a hospital's administrative appeal or judicial review, at which time the remaining portion of the payments due to the eligible hospitals shall be made. A partial distribution may be based upon estimates and trends calculated by the office.

(f) For purposes of this section:

(1) the Medicaid ~~shortfall~~ **supplemental payment** of a hospital established and operated under IC 16-22-2 or IC 16-23 is calculated as follows:

STEP ONE: The office shall identify the inpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year

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by the hospital.

STEP TWO: For the inpatient hospital services identified under STEP ONE, the office shall calculate the payments made under this article and under the state Medicaid plan to the hospital, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the amount that would have been paid by the office for the inpatient hospital services described in STEP ONE under Medicare payment principles; and

(2) a hospital's Medicaid ~~shortfall~~ **supplemental payment** is equal to the amount by which the amount calculated in STEP THREE of subdivision (1) is greater than the amount calculated in STEP TWO of subdivision (1).

(g) The actual distribution of the amount calculated under STEP FIVE of subsection (b) to a hospital established and operated under IC 16-22-8 shall be made under the terms and conditions provided for the hospital in the state plan for medical assistance. Payment to a hospital under STEP FIVE of subsection (b) is not a condition precedent to the tender of payments to hospitals under STEP SEVEN of subsection (b).

SECTION 14. IC 12-15-15-1.3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1.3. (a) This section applies to a hospital that is:

(1) licensed under IC 16-21; and

(2) established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23.

(b) For a state fiscal year ending after June 30, 2003, in addition to reimbursement received under section 1 of this chapter, a hospital is entitled to reimbursement in an amount calculated as follows:

STEP ONE: The office shall identify the aggregate outpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by hospitals established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23.

STEP TWO: For the aggregate outpatient hospital services identified under STEP ONE, the office shall calculate the aggregate payments made under this article and under the state Medicaid plan to hospitals established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of

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the amount that would have been paid in the aggregate by the office under Medicare payment principles for the outpatient hospital services described in STEP ONE.

STEP FOUR: Subtract the amount calculated under STEP TWO from the amount calculated under STEP THREE.

STEP FIVE: Subject to subsection (g), from the amount calculated under STEP FOUR, allocate to a hospital established and operated under IC 16-22-8 an amount equal to one hundred percent (100%) of the difference between:

(A) the total cost for the hospital's provision of outpatient services covered under this article for the hospital's fiscal year ending during the state fiscal year; and

(B) the total payment to the hospital for its provision of outpatient services covered under this article for the hospital's fiscal year ending during the state fiscal year, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP SIX: Subtract the amount calculated under STEP FIVE from the amount calculated under STEP FOUR.

STEP SEVEN: Distribute an amount equal to the amount calculated under STEP SIX to the eligible hospitals established and operated under IC 16-22-2 or IC 16-23 described in subsection (c) in proportion to each hospital's Medicaid ~~shortfall~~ **supplemental payment** as defined in subsection (f).

(c) ~~Subject to subsection (c), the reimbursement for a state fiscal year under this section consists of payments made before December 31 following the end of the state fiscal year.~~ A hospital is not eligible for a payment described in this ~~subsection~~ **section** unless an intergovernmental transfer is made ~~under subsection (d).~~ **by the hospital or on behalf of the hospital.**

(d) Subject to subsection (e), a hospital may make an intergovernmental transfer under this subsection, or an intergovernmental transfer may be made on behalf of the hospital, after the close of each state fiscal year. An intergovernmental transfer under this subsection must be made to the Medicaid indigent care trust fund in an amount equal to a percentage, as determined by the office, of the amount to be distributed to the hospital under ~~STEP SEVEN of~~ subsection (b). ~~In determining the percentage, the office shall apply the same percentage of not more than eighty-five percent (85%) to all hospitals eligible for reimbursement under STEP SEVEN of subsection (b).~~ The office shall use the intergovernmental transfer to fund payments made under this section. ~~and as otherwise provided under IC 12-15-20-2(8).~~

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(e) A hospital making an intergovernmental transfer under ~~subsection (d)~~ **this section** may appeal under IC 4-21.5 the amount determined by the office to be paid by the hospital under ~~STEP SEVEN of~~ subsection (b). The periods described in subsections (c) and (d) for the hospital to make an intergovernmental transfer are tolled pending the administrative appeal and any judicial review initiated by the hospital under IC 4-21.5. The distribution to other hospitals under ~~STEP SEVEN of~~ subsection (b) may not be delayed due to an administrative appeal or judicial review instituted by a hospital under this subsection. If necessary, the office may make a partial distribution to the other eligible hospitals under ~~STEP SEVEN of~~ subsection (b) pending the completion of a hospital's administrative appeal or judicial review, at which time the remaining portion of the payments due to the eligible hospitals must be made. A partial distribution may be calculated by the office based upon estimates and trends.

(f) For purposes of this section:

(1) the Medicaid ~~shortfall~~ **supplemental payment** of a hospital established and operated under IC 16-22-2 or IC 16-23 is calculated as follows:

STEP ONE: The office shall identify the outpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by the hospital.

STEP TWO: For the outpatient hospital services identified under STEP ONE, the office shall calculate the payments made under this article and under the state Medicaid plan to the hospital, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the amount that would have been paid by the office for the outpatient hospital services described in STEP ONE under Medicare payment principles; and

(2) a hospital's Medicaid ~~shortfall~~ **supplemental payment** is equal to the amount by which the amount calculated in STEP THREE of subdivision (1) is greater than the amount calculated in STEP TWO of subdivision (1).

(g) The actual distribution of the amount calculated under STEP FIVE of subsection (b) to a hospital established and operated under IC 16-22-8 shall be made under the terms and conditions provided for the hospital in the state plan for medical assistance. Payment to a hospital under STEP FIVE of subsection (b) is not a condition precedent to the tender of payments to hospitals under STEP SEVEN

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of subsection (b).

SECTION 15. IC 12-15-15-1.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1.5. (a) This section applies to a hospital that:

(1) is licensed under IC 16-21;

(2) is not a unit of state or local government; and

(3) is not owned or operated by a unit of state or local government.

(b) For a state fiscal year ending after June 30, 2003, **and before July 1, 2005,** in addition to reimbursement received under section 1 of this chapter, a hospital eligible under this section is entitled to reimbursement in an amount calculated as follows:

STEP ONE: The office shall identify the total inpatient hospital services and the total outpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by the hospitals described in subsection (a).

STEP TWO: For the total inpatient hospital services and the total outpatient hospital services identified under STEP ONE, the office shall calculate the aggregate payments made under this article and under the state Medicaid plan to hospitals described in subsection (a), excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the amount that would have been paid in the aggregate by the office for the inpatient hospital services and the outpatient hospital services identified in STEP ONE under Medicare payment principles.

STEP FOUR: Subtract the amount calculated under STEP TWO from the amount calculated under STEP THREE.

STEP FIVE: Distribute an amount equal to the amount calculated under STEP FOUR to the eligible hospitals described in subsection (a) as follows:

(A) Subject to the availability of funds under IC 12-15-20-2(8)(D) to serve as the non-federal share of such payment, the first ten million dollars ($10,000,000) of the amount calculated under STEP FOUR for a state fiscal year shall be paid to a hospital described in subsection (a) that has more than seventy thousand (70,000) Medicaid inpatient days.

(B) Following the payment to the hospital under clause (A) and subject to the availability of funds under IC 12-15-20-2(8)(D) to serve as the non-federal share of such

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payments, the remaining amount calculated under STEP FOUR for a state fiscal year shall be paid to all hospitals described in subsection (a). The payments shall be made on a pro rata basis based on the hospitals' Medicaid inpatient days or other payment methodology approved by the Centers for Medicare and Medicaid Services.

(C) Subject to IC 12-15-20.7, in the event the entirety of the amount calculated under STEP FOUR is not distributed following the payments made under clauses (A) and (B), the remaining amount may be paid to hospitals described in subsection (a) that are eligible under this clause. A hospital is eligible for a payment under this clause only if the non-federal share of the hospital's payment is provided by or on behalf of the hospital. The remaining amount shall be paid to those eligible hospitals on a pro rata basis in relation to all hospitals eligible under this clause based on the hospitals' Medicaid inpatient days or other payment methodology approved by the Centers for Medicare and Medicaid Services.

(D) For purposes of the clauses (A), (B) and (C), a hospital's Medicaid inpatient days are based on the Medicaid inpatient days allowed for the hospital by the office for purposes of the office's most recent determination of eligibility for the Medicaid disproportionate payment program under IC 12-15-16.

~~(c) Reimbursement for a state fiscal year under this section consists of payments made after the close of each state fiscal year. Payment for a state fiscal year ending after June 30, 2003, shall be made before December 31 following the end of the state fiscal year.~~

(c) For state fiscal years ending after July 1, 2005, in addition to reimbursement received under section 1 of this chapter, a hospital eligible under this section is entitled to reimbursement in an amount calculated as follows:

STEP ONE: The office shall identify the total inpatient hospital services and the total outpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by a hospital described in subsection (a).

STEP TWO: For the total inpatient hospital services and the total outpatient hospital services identified under STEP ONE, the office shall calculate the total payments made under this article and under the state Medicaid plan to a hospital described in subsection (a), excluding payments made under

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IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the total amount that would have been paid by the office for the inpatient hospital services and the outpatient hospital services identified in STEP ONE under Medicare payment principles.

STEP FOUR: Subtract the amount calculated under STEP TWO from the amount calculated under STEP THREE.

STEP FIVE: Distribute an amount equal to the amount calculated under STEP FOUR to the eligible hospitals described in subsection (a) as follows:

(A) Subject to the availability of funds under IC 12-15-20-2(8) to serve as the non-federal share of the payments, the amount calculated under STEP FOUR for a state fiscal year shall be paid to all hospitals described in subsection (a). The payments shall be made on a pro rata basis based on the hospitals' Medicaid inpatient days or, if the federal Centers for Medicare and Medicaid Services does not approve that methodology, another payment methodology approved by the federal Centers for Medicare and Medicaid Services. For purposes of this clause, a hospital's Medicaid inpatient days are the hospital's in-state Medicaid fee for service and managed care paid days for the state fiscal year referenced in STEP ONE, as determined by the office.

(B) Subject to IC 12-15-20.7, if the entirety of the amount calculated under STEP FOUR is not distributed following the payments made under clause (A), the remaining amount shall be paid to hospitals described in subsection (a) that are eligible under this clause. A hospital is eligible for a payment under this clause only if the hospital:

(i) has less than seventy thousand (70,000) Medicaid inpatient days annually;

(ii) was eligible for Medicaid disproportionate share hospital payments for the state fiscal year ending June 30, 1998, or the hospital met the office's Medicaid disproportionate share payment criteria for payment under IC 12-15-19-2.1 based upon state fiscal year 1998 data and received a Medicaid disproportionate share payment for the state fiscal year ending June 30, 2001; and

(iii) received a Medicaid disproportionate share payment

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under IC 12-15-19-2.1 for state fiscal years 2001, 2002, 2003, and 2004.

The amount of a hospital's payment under this clause is subject to the availability of Medicaid indigent care trust funds or, if none are available, the non-federal share of the hospital's payment being provided by or on behalf of the hospital. The payment to each hospital shall equal the hospital's hospital specific limit, as defined under 42 U.S.C. 1396r-4, when the payment is combined with any other Medicaid payments made to the hospital. For state fiscal years ending before July 1, 2008, the total payments made under this clause may not exceed a total amount of sixty-eight million dollars ($68,000,000). For a state fiscal year ending after June 30, 2008, the total payments made under this clause may not exceed a total amount of sixty-eight million dollars ($68,000,000) plus the annual percentage growth in the state's aggregate Medicaid upper payment limit, as calculated by the office.

(C) Subject to IC 12-15-20.7, if the entirety of the amount calculated under STEP FOUR is not distributed following the payments made under clauses (A) and (B), the remaining amount may be paid to hospitals described in subsection (a) that are eligible under this clause. A hospital is eligible for a payment under this clause if the hospital:

(i) has less than seventy thousand (70,000) Medicaid inpatient days annually;

(ii) has received or is eligible to receive Medicaid disproportionate share payments under IC 12-15-19-2.1 for state fiscal years 2002, 2003, 2004, and for each state fiscal year after 2004; and

(iii) provides, or has provided on the hospital's behalf, the non-federal share of the hospital's payment.

A payment to a hospital under this clause is subject to the availability of non-federal matching funds. The payment to each hospital shall not exceed ninety percent (90%) of the hospital's Medicaid shortfall. As used in this clause, Medicaid shortfall is the amount of the hospital's Medicaid costs less the hospital's Medicaid reimbursement, including any payments received by the hospital under IC 12-15-15-9 and IC 12-15-15-9.5. For state fiscal years ending before July 1, 2008, the total payments made under this clause may not exceed a total amount of twenty-three million five

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hundred thousand dollars ($23,500,000). For a state fiscal year ending after June 30, 2008, the total payments made under this clause may not exceed a total amount of twenty-three million five hundred thousand dollars ($23,500,000) plus the annual percentage growth in the state's aggregate Medicaid upper payment limit, as determined by the office.

(D) Subject to IC 12-15-20.7, if the entirety of the amount calculated under STEP FOUR is not distributed following the payments made under clauses (A) through (C), the remaining amount shall be paid to hospitals described in subsection (a) that are eligible under this clause. A hospital is eligible for payment under this clause if the hospital provides, or has provided on the hospital's behalf, the non-federal share of the hospital's payment.

(E) As used in clauses (A) through (D), a hospital's Medicaid inpatient days are based on the hospital's in-state Medicaid fee for service and managed care paid days for the state fiscal year referenced in STEP ONE, as determined by the office.

(d) A hospital described in subsection (a) may appeal under IC 4-21.5 the amount determined by the office to be paid to the hospital under STEP FIVE of subsection (b) **or subsection (c).** The distribution to other hospitals under STEP FIVE of subsection (b) **or subsection (c)** may not be delayed due to an administrative appeal or judicial review instituted by a hospital under this subsection. If necessary, the office may make a partial distribution to the other eligible hospitals under STEP FIVE of subsection (b) **or subsection (c)** pending the completion of a hospital's administrative appeal or judicial review, at which time the remaining portion of the payments due to the eligible hospitals shall be made. A partial distribution may be based on estimates and trends calculated by the office.

SECTION 16. IC 12-15-15-9 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 9. (a) For purposes of this section and IC 12-16-7.5-4.5, a payable claim is attributed to a county if the payable claim is submitted to the division by a hospital licensed under IC 16-21-2 for payment under IC 12-16-7.5 for care provided by the hospital to an individual who qualifies for the hospital care for the indigent program under IC 12-16-3.5-1 or IC 12-16-3.5-2 and:

(1) who is a resident of the county;

(2) who is not a resident of the county and for whom the onset of

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the medical condition that necessitated the care occurred in the county; or

(3) whose residence cannot be determined by the division and for whom the onset of the medical condition that necessitated the care occurred in the county.

(b) For each state fiscal year ending after June 30, 2003, **and before July 1, 2006,** a hospital licensed under IC 16-21-2 that submits to the division during the state fiscal year a payable claim under IC 12-16-7.5 is entitled to a payment under ~~this section.~~ **subsection (c).**

(c) Except as provided in section 9.8 of this chapter and subject to section 9.6 of this chapter, for a state fiscal year, the office shall pay to a hospital referred to in subsection (b) an amount equal to the amount, based on information obtained from the division and the calculations and allocations made under IC 12-16-7.5-4.5, that the office determines for the hospital under STEP SIX of the following STEPS:

STEP ONE: Identify:

(A) each hospital that submitted to the division one (1) or more payable claims under IC 12-16-7.5 during the state fiscal year; and

(B) the county to which each payable claim is attributed.

STEP TWO: For each county identified in STEP ONE, identify:

(A) each hospital that submitted to the division one (1) or more payable claims under IC 12-16-7.5 attributed to the county during the state fiscal year; and

(B) the total amount of all hospital payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year.

STEP THREE: For each county identified in STEP ONE, identify the amount of county funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).

STEP FOUR: For each hospital identified in STEP ONE, with respect to each county identified in STEP ONE, calculate the hospital's percentage share of the county's funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b). Each hospital's percentage share is based on the total amount of the hospital's payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year, calculated as a percentage of the total amount of all hospital payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year.

STEP FIVE: Subject to subsection (j), for each hospital identified in STEP ONE, with respect to each county identified in STEP

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ONE, multiply the hospital's percentage share calculated under STEP FOUR by the amount of the county's funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).

STEP SIX: Determine the sum of all amounts calculated under STEP FIVE for each hospital identified in STEP ONE with respect to each county identified in STEP ONE.

(d) For state fiscal years beginning after June 30, 2006, a hospital that received a payment determined under STEP SIX of subsection (c) for the state fiscal year ending June 30, 2006, shall be paid in an amount equal to the amount determined for the hospital under STEP SIX of subsection (c) for the state fiscal year ending June 30, 2006.

~~(d)~~ **(e)** A hospital's payment under subsection (c) **or (d)** is in the form of a Medicaid ~~add-on~~ **supplemental** payment. The amount of a hospital's ~~add-on~~ **Medicaid supplemental** payment is subject to the availability of funding for the non-federal share of the payment under subsection ~~(c).~~ **(f).** The office shall make the payments under ~~subsection~~ **subsections** (c) **and (d)** before December 15 that next succeeds the end of the state fiscal year.

~~(e)~~ **(f)** The non-federal share of a payment to a hospital under subsection (c) **or (d)** is funded from the funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) of each county to which a payable claim under IC 12-16-7.5 submitted to the division during the state fiscal year by the hospital is attributed.

~~(f)~~ **(g)** The amount of a county's transferred funds available to be used to fund the non-federal share of a payment to a hospital under subsection (c) **or (d)** is an amount that bears the same proportion to the total amount of funds of the county transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) that the total amount of the hospital's payable claims under IC 12-16-7.5 attributed to the county submitted to the division during the state fiscal year bears to the total amount of all hospital payable claims under IC 12-16-7.5 attributed to the county submitted to the division during the state fiscal year.

~~(g)~~ **(h)** Any county's funds identified in subsection ~~(f)~~ **(g)** that remain after the non-federal share of a hospital's payment has been funded are available to serve as the non-federal share of a payment to a hospital under section 9.5 of this chapter.

~~(h)~~ **(i)** For purposes of this section, "payable claim" has the meaning set forth in IC 12-16-7.5-2.5(b)(1).

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~~(i)~~ **(j)** For purposes of this section:

(1) the amount of a payable claim is an amount equal to the amount the hospital would have received under the state's fee-for-service Medicaid reimbursement principles for the hospital care for which the payable claim is submitted under IC 12-16-7.5 if the individual receiving the hospital care had been a Medicaid enrollee; and

(2) a payable hospital claim under IC 12-16-7.5 includes a payable claim under IC 12-16-7.5 for the hospital's care submitted by an individual or entity other than the hospital, to the extent permitted under the hospital care for the indigent program.

~~(j)~~ **(k)** The amount calculated under STEP FIVE of subsection (c) for a hospital with respect to a county may not exceed the total amount of the hospital's payable claims attributed to the county during the state fiscal year.

SECTION 17. IC 12-15-15-9.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 9.5. (a) For purposes of this section and IC 12-16-7.5-4.5, a payable claim is attributed to a county if the payable claim is submitted to the division by a hospital licensed under IC 16-21-2 for payment under IC 12-16-7.5 for care provided by the hospital to an individual who qualifies for the hospital care for the indigent program under IC 12-16-3.5-1 or IC 12-16-3.5-2 and;

(1) who is a resident of the county;

(2) who is not a resident of the county and for whom the onset of the medical condition that necessitated the care occurred in the county; or

(3) whose residence cannot be determined by the division and for whom the onset of the medical condition that necessitated the care occurred in the county.

(b) For each state fiscal year ending after June 30, 2003, **but before July 1, 2006,** a hospital licensed under IC 16-21-2:

(1) that submits to the division during the state fiscal year a payable claim under IC 12-16-7.5; and

(2) whose payment under section 9(c) of this chapter was less than the total amount of the hospital's payable claims under IC 12-16-7.5 submitted by the hospital to the division during the state fiscal year;

is entitled to a payment under ~~this section.~~ **subsection (c).**

(c) Except as provided in section 9.8 of this chapter and subject to section 9.6 of this chapter, for a state fiscal year, the office shall pay to a hospital referred to in subsection (b) an amount equal to the amount,

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based on information obtained from the division and the calculations and allocations made under IC 12-16-7.5-4.5, that the office determines for the hospital under STEP EIGHT of the following STEPS:

STEP ONE: Identify each county whose transfer of funds to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) for the state fiscal year was less than the total amount of all hospital payable claims attributed to the county and submitted to the division during the state fiscal year.

STEP TWO: For each county identified in STEP ONE, calculate the difference between the amount of funds of the county transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) and the total amount of all hospital payable claims attributed to the county and submitted to the division during the state fiscal year.

STEP THREE: Calculate the sum of the amounts calculated for the counties under STEP TWO.

STEP FOUR: Identify each hospital whose payment under section 9(c) of this chapter was less than the total amount of the hospital's payable claims under IC 12-16-7.5 submitted by the hospital to the division during the state fiscal year.

STEP FIVE: Calculate for each hospital identified in STEP FOUR the difference between the hospital's payment under section 9(c) of this chapter and the total amount of the hospital's payable claims under IC 12-16-7.5 submitted by the hospital to the division during the state fiscal year.

STEP SIX: Calculate the sum of the amounts calculated for each of the hospitals under STEP FIVE.

STEP SEVEN: For each hospital identified in STEP FOUR, calculate the hospital's percentage share of the amount calculated under STEP SIX. Each hospital's percentage share is based on the amount calculated for the hospital under STEP FIVE calculated as a percentage of the sum calculated under STEP SIX.

STEP EIGHT: For each hospital identified in STEP FOUR, multiply the hospital's percentage share calculated under STEP SEVEN by the sum calculated under STEP THREE. The amount calculated under this STEP for a hospital may not exceed the amount by which the hospital's total payable claims under IC 12-16-7.5 submitted during the state fiscal year exceeded the amount of the hospital's payment under section 9(c) of this chapter.

(d) For state fiscal years beginning after June 30, 2006, a hospital that received a payment determined under STEP EIGHT

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of subsection (c) for the state fiscal year ending June 30, 2006, will be paid an amount equal to the amount determined for the hospital under STEP EIGHT of subsection (c) for the state fiscal year ending June 30, 2006.

~~(d)~~ **(e)** A hospital's payment under subsection (c) **or (d)** is in the form of a Medicaid ~~add-on~~ **supplemental** payment. The amount of the hospital's add-on payment is subject to the availability of funding for the non-federal share of the payment under subsection ~~(c).~~ **(f).** The office shall make the payments under subsection (c) **or (d)** before December 15 that next succeeds the end of the state fiscal year.

~~(e)~~ **(f)** The non-federal share of a payment to a hospital under subsection (c) **or (d)** is derived from funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) and not expended under section 9 of this chapter. ~~To the extent possible, the funds shall be derived on a proportional basis from the funds transferred by each county identified in subsection (c), STEP ONE:~~

~~(1) to which at least one (1) payable claim submitted by the hospital to the division during the state fiscal year is attributed, and~~

~~(2) whose funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) were not completely expended under section 9 of this chapter.~~

~~The amount available to be derived from the remaining funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) to serve as the non-federal share of the payment to a hospital under subsection (c) is an amount that bears the same proportion to the total amount of funds transferred by all the counties identified in subsection (c), STEP ONE, that the amount calculated for the hospital under subsection (c), STEP FIVE, bears to the amount calculated under subsection (c), STEP SIX.~~

~~(f)~~ **(g)** Except as provided in subsection ~~(g),~~ **(h),** the office may not make a payment under this section until the payments due under section 9 of this chapter for the state fiscal year have been made.

~~(g)~~ **(h)** If a hospital appeals a decision by the office regarding the hospital's payment under section 9 of this chapter, the office may make payments under this section before all payments due under section 9 of this chapter are made if:

(1) a delay in one (1) or more payments under section 9 of this chapter resulted from the appeal; and

(2) the office determines that making payments under this section while the appeal is pending will not unreasonably affect the interests of hospitals eligible for a payment under this section.

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~~(h)~~ **(i)** Any funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) remaining after payments are made under this section shall be used as provided in ~~IC 12-15-20-2(8)(D).~~ **IC 12-15-20-2(8).**

~~(i)~~ **(j)** For purposes of this section:

(1) "payable claim" has the meaning set forth in IC 12-16-7.5-2.5(b);

(2) the amount of a payable claim is an amount equal to the amount the hospital would have received under the state's fee-for-service Medicaid reimbursement principles for the hospital care for which the payable claim is submitted under IC 12-16-7.5 if the individual receiving the hospital care had been a Medicaid enrollee; and

(3) a payable hospital claim under IC 12-16-7.5 includes a payable claim under IC 12-16-7.5 for the hospital's care submitted by an individual or entity other than the hospital, to the extent permitted under the hospital care for the indigent program.

SECTION 18. IC 12-15-15-9.8 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 9.8. ~~(a) This section applies only if the office determines, based on information received from the United States Centers for Medicare and Medicaid Services, that a state Medicaid plan amendment implementing the payment methodology in:~~

~~(1) section 9(c) of this chapter; or~~

~~(2) section 9.5(c) of this chapter;~~

~~will not be approved by the United States Centers for Medicare and Medicaid Services.~~

~~(b)~~ The office may amend the state Medicaid plan to implement an alternative payment methodology. ~~to the payment methodology under section 9 of this chapter. The alternative payment methodology must provide each hospital that would have received a payment under section 9(c) of this chapter during a state fiscal year with an amount for the state fiscal year that is as equal as possible to the amount each hospital would have received under the payment methodology under section 9(c) of this chapter. A payment methodology implemented under this subsection is in place of the payment methodology under section 9(c) of this chapter.~~

~~(c) The office may amend the state Medicaid plan to implement an alternative payment methodology to the payment methodology under section 9.5 of this chapter. The alternative payment methodology must provide each hospital that would have received a payment under section 9.5(c) of this chapter during a state fiscal year with an amount~~

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~~for the state fiscal year that is as equal as possible to the amount each hospital would have received under the payment methodology under section 9.5(c) of this chapter. A payment methodology implemented under this subsection is in place of the payment methodology under section 9.5(c) of this chapter.~~

SECTION 19. IC 12-15-15-10 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 10. (a) This section applies to a hospital that:

(1) is licensed under IC 16-21; and

(2) qualifies as a provider under **IC 12-15-16, IC 12-15-17, or IC 12-15-19 of** the Medicaid disproportionate share provider program.

(b) The office may, after consulting with affected providers, do one (1) or more of the following:

~~(1) Expand the payment program established under section 1.1(b) of this chapter to include all hospitals described in subsection (a).~~

~~(2)~~ **(1)** Establish a nominal charge hospital payment program.

~~(3)~~ **(2)** Establish any other permissible payment program.

(c) A program expanded or established under this section is subject to the availability of:

(1) intergovernmental transfers; ~~or~~

(2) funds certified as being eligible for federal financial participation; **or**

(3) other permissible sources of non-federal share dollars.

(d) The office may not implement a program under this section until the federal Centers for Medicare and Medicaid Services approves the provisions regarding the program in the amended state plan for medical assistance.

(e) The office may determine not to continue to implement a program established under this section if federal financial participation is not available.

SECTION 20. IC 12-15-19-2.1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2.1. (a) For each state fiscal year ending on or after June 30, 2000, the office shall develop a disproportionate share payment methodology that ensures that each hospital qualifying for disproportionate share payments under IC 12-15-16-1(a) timely receives total disproportionate share payments that do not exceed the hospital's hospital specific limit provided under 42 U.S.C. 1396r-4(g). The payment methodology as developed by the office must:

(1) maximize disproportionate share hospital payments to qualifying hospitals to the extent practicable;

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(2) take into account the situation of those qualifying hospitals that have historically qualified for Medicaid disproportionate share payments; and

(3) ensure that payments net of intergovernmental transfers made by or on behalf of qualifying hospitals are equitable.

(b) Total disproportionate share payments to a hospital under this chapter shall not exceed the hospital specific limit provided under 42 U.S.C. 1396r-4(g). The hospital specific limit for a state fiscal year shall be determined by the office taking into account data provided by each hospital that is considered reliable by the office based on a system of periodic audits, the use of trending factors, and an appropriate base year determined by the office. The office may require independent certification of data provided by a hospital to determine the hospital's hospital specific limit.

(c) The office shall include a provision in each amendment to the state plan regarding Medicaid disproportionate share payments that the office submits to the federal Centers for Medicare and Medicaid Services that, as provided in 42 CFR 447.297(d)(3), allows the state to make additional disproportionate share expenditures after the end of each federal fiscal year that relate back to a prior federal fiscal year. However, the total disproportionate share payments to:

(1) each individual hospital; and

(2) all qualifying hospitals in the aggregate;

may not exceed the limits provided by federal law and regulation.

(d) ~~The office shall, in each state fiscal year, provide sufficient funds for acute care hospitals licensed under IC 16-21 that qualify for disproportionate share payments under IC 12-15-16-1(a). Funds provided under this subsection:~~

~~(1) do not include funds transferred by other governmental units to the Medicaid indigent care trust fund; and~~

~~(2) must be in an amount equal to the amount that results from the following calculation:~~

~~STEP ONE: Multiply twenty-six million dollars ($26,000,000) by the federal medical assistance percentage.~~

~~STEP TWO: Subtract the amount determined under STEP ONE from twenty-six million dollars ($26,000,000).~~

A hospital that receives a payment under clause (B) of STEP FIVE of IC 12-15-15-1.5(c) is not eligible for a disproportionate share payment under this section.

SECTION 21. IC 12-15-19-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 6. (a) The office is not required to make disproportionate share payments under this chapter

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from the Medicaid indigent care trust fund established by IC 12-15-20-1 until the fund has received sufficient deposits to permit the office to make the state's share of the required disproportionate share payments.

(b) If:

(1) sufficient deposits have not been received; **or**

(2) the statewide Medicaid disproportionate share allocation is not sufficient to provide federal financial participation for the entirety of all eligible disproportionate share hospitals' specific limits;

the office ~~shall~~ **may** reduce disproportionate share payments **under IC 12-15-19-2.1** to ~~all~~ eligible institutions by ~~the same~~ **a** percentage **as long as, for each state fiscal year beginning after June 30, 2006, a hospital established under IC 16-22-8 receives at least sixty percent (60%) of the hospital's remaining hospital specific limit for each state fiscal year.** The percentage reduction shall be sufficient to ensure that payments do not exceed the **statewide Medicaid disproportionate share allocation or the** amounts that can be financed with the ~~state~~ **non-federal** share that is in the fund, **intergovernmental transfers, certifications of public expenditures, or other permissible sources of non-federal match.**

SECTION 22. IC 12-15-19-8 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 8. (a) A provider that qualifies as a municipal disproportionate share provider under IC 12-15-16-1 shall receive a disproportionate share adjustment, subject to the provider's hospital specific limits described in subsection (b) **and the total amount available for municipal disproportionate share payments in subsection (d),** as follows:

(1) For each state fiscal year ending on or after June 30, 1998, an amount shall be distributed to each provider qualifying as a municipal disproportionate share provider under IC 12-15-16-1. The total amount distributed shall not exceed the sum of all hospital specific limits for all qualifying providers.

(2) For each municipal disproportionate share provider qualifying under IC 12-15-16-1 to receive disproportionate share payments, the amount in subdivision (1) shall be reduced by ~~the amount of disproportionate share payments received by the provider under IC 12-15-16-6 or sections 1 or 2.1 of this chapter.~~ **all Medicaid payments, including Medicaid supplemental payments and other Medicaid disproportionate share payments received by the provider.** The office shall develop a disproportionate share provider payment methodology that ensures that each municipal

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disproportionate share provider receives disproportionate share payments that do not exceed the provider's hospital specific limit specified in subsection (b). The methodology developed by the office shall ensure that a municipal disproportionate share provider receives, to the extent possible, disproportionate share payments that, when combined with any other ~~disproportionate share~~ **Medicaid supplemental** payments owed to the provider, ~~equals~~ **do not exceed** the provider's hospital specific limits.

(b) Total disproportionate share payments to a provider under this chapter and IC 12-15-16 shall not exceed the hospital specific limit provided under 42 U.S.C. 1396r-4(g). The hospital specific limit for state fiscal years ending on or before June 30, 1999, shall be determined by the office taking into account data provided by each hospital for the hospital's most recent fiscal year or, if a change in fiscal year causes the most recent fiscal period to be less than twelve (12) months, twelve (12) months of data compiled to the end of the provider's fiscal year that ends within the most recent state fiscal year, as certified to the office by an independent certified public accounting firm. The hospital specific limit for all state fiscal years ending on or after June 30, 2000, shall be determined by the office taking into account data provided by each hospital that is deemed reliable by the office based on a system of periodic audits, the use of trending factors, and an appropriate base year determined by the office. The office may require independent certification of data provided by a hospital to determine the hospital's hospital specific limit.

(c) For each of the state fiscal years:

(1) beginning July 1, 1998, and ending June 30, 1999; and

(2) beginning July 1, 1999, and ending June 30, 2000;

the total municipal disproportionate share payments available under this section to qualifying municipal disproportionate share providers is twenty-two million dollars ($22,000,000).

(d) For each of the state fiscal years ending after June 30, 2006, the total municipal disproportionate share payments available under this section to qualifying municipal disproportionate share providers may not exceed thirty-five million dollars ($35,000,000).

SECTION 23. IC 12-15-19-10, AS AMENDED BY P.L.2-2005, SECTION 49, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 10. For state fiscal years beginning after June 30, 2000, **and ending June 30, 2003**, the state shall pay providers as follows:

(1) The state shall make municipal disproportionate share provider payments to providers qualifying under IC 12-15-16-1(b)

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until the state exceeds the state disproportionate share allocation (as defined in 42 U.S.C. 1396r-4(f)(2)).

(2) After the state makes all payments under subdivision (1), if the state fails to exceed the state disproportionate share allocation (as defined in 42 U.S.C. 1396r-4(f)(2)), the state shall make disproportionate share provider payments to providers qualifying under IC 12-15-16-1(a).

(3) After the state makes all payments under subdivision (2), if the state fails to exceed the state disproportionate share allocation (as defined in 42 U.S.C. 1396r-4(f)(2)), or the state limit on disproportionate share expenditures for institutions for mental diseases (as defined in 42 U.S.C. 1396r-4(h)), the state shall make community mental health center disproportionate share provider payments to providers qualifying under IC 12-15-16-1(c).

SECTION 24. IC 12-15-20-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2. The Medicaid indigent care trust fund is established to pay the non-federal share of the following:

(1) Enhanced disproportionate share payments to providers under IC 12-15-19-1.

(2) Subject to subdivision (8), disproportionate share payments to providers under IC 12-15-19-2.1.

(3) Medicaid payments for pregnant women described in IC 12-15-2-13 and infants and children described in IC 12-15-2-14.

(4) Municipal disproportionate share payments to providers under IC 12-15-19-8.

(5) Payments to hospitals under IC 12-15-15-9.

(6) Payments to hospitals under IC 12-15-15-9.5.

(7) Payments, funding, and transfers as otherwise provided in clauses (8)(D), ~~and~~ (8)(F), **and (8)(G).**

(8) Of the intergovernmental transfers deposited into the Medicaid indigent care trust fund, the following apply:

(A) The entirety of the intergovernmental transfers deposited into the Medicaid indigent care trust fund for state fiscal years ending on or before June 30, 2000, shall be used to fund the state's share of the disproportionate share payments to providers under IC 12-15-19-2.1.

(B) Of the intergovernmental transfers deposited into the Medicaid indigent care trust fund for the state fiscal year ending June 30, 2001, an amount equal to one hundred percent (100%) of the total intergovernmental transfers deposited into

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the Medicaid indigent care trust fund for the state fiscal year beginning July 1, 1998, and ending June 30, 1999, shall be used to fund the state's share of disproportionate share payments to providers under IC 12-15-19-2.1. The remainder of the intergovernmental transfers, if any, for the state fiscal year shall be used to fund the state's share of additional Medicaid payments to hospitals licensed under IC 16-21 pursuant to a methodology adopted by the office.

(C) Of the intergovernmental transfers deposited into the Medicaid indigent care trust fund, for state fiscal years beginning July 1, 2001, and July 1, 2002, an amount equal to:

(i) one hundred percent (100%) of the total intergovernmental transfers deposited into the Medicaid indigent care trust fund for the state fiscal year beginning July 1, 1998; minus

(ii) an amount equal to the amount deposited into the Medicaid indigent care trust fund under IC 12-15-15-9(d) for the state fiscal years beginning July 1, 2001, and July 1, 2002;

shall be used to fund the state's share of disproportionate share payments to providers under IC 12-15-19-2.1. The remainder of the intergovernmental transfers, if any, must be used to fund the state's share of additional Medicaid payments to hospitals licensed under IC 16-21 pursuant to a methodology adopted by the office.

(D) Of the intergovernmental transfers, which shall include amounts transferred under IC 12-16-7.5-4.5(b), STEP FOUR, deposited into the Medicaid indigent care trust fund for state fiscal years ending after June 30, 2003, **but before July 1, 2005,** an amount equal to:

(i) one hundred percent (100%) of the total intergovernmental transfers deposited into the Medicaid indigent care trust fund for the state fiscal year beginning July 1, 1998, and ending June 30, 1999; minus

(ii) an amount equal to the amount deposited into the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) for the state fiscal year ending after June 30, 2003;

shall be used to fund the non-federal share of disproportionate share payments to providers under IC 12-15-19-2.1. The remainder of the intergovernmental transfers, if any, for the state fiscal years shall be used to fund, in descending order of

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priority, the non-federal share of payments to hospitals under IC 12-15-15-9, the non-federal share of payments to hospitals under IC 12-15-15-9.5, the amount to be transferred under clause (F), and the non-federal share of payments under clauses (A) and (B) of STEP FIVE of IC 12-15-15-1.5(b).

(E) The total amount of intergovernmental transfers used to fund the non-federal share of payments to hospitals under IC 12-15-15-9 and IC 12-15-15-9.5 shall not exceed the amount calculated under STEP TWO of the following formula:

STEP ONE: Calculate the total amount of funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).

STEP TWO: Multiply the state Medicaid medical assistance percentage for the state fiscal year for which the payments under IC 12-15-15-9 and IC 12-15-15-9.5 are to be made by the amount calculated under STEP ONE.

(F) As provided in clause (D), for each fiscal year ending after June 30, 2003, **but before July 1, 2005,** an amount equal to the amount calculated under STEP THREE of the following formula shall be transferred to the office:

STEP ONE: Calculate the product of thirty-five million dollars ($35,000,000) multiplied by the federal medical assistance percentage for federal fiscal year 2003.

STEP TWO: Calculate the sum of the amounts, if any, reasonably estimated by the office to be transferred or otherwise made available to the office for the state fiscal year, and the amounts, if any, actually transferred or otherwise made available to the office for the state fiscal year, under arrangements whereby the office and a hospital licensed under IC 16-21-2 agree that an amount transferred or otherwise made available to the office by the hospital or on behalf of the hospital shall be included in the calculation under this STEP.

STEP THREE: Calculate the amount by which the product calculated under STEP ONE exceeds the sum calculated under STEP TWO.

(G) For each fiscal year ending after June 30, 2005, the total amount of intergovernmental transfers deposited into the Medicaid indigent care trust fund shall be used as follows:

(i) Thirty million dollars ($30,000,000) shall be transferred to the office for the Medicaid budget.

(ii) An amount not to exceed eleven million six hundred

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fifty thousand dollars ($11,650,000) to fund the non-federal share of payments to hospitals under IC 12-15-15-9 and IC 12-15-15-9.5.

(iii) An amount not to exceed eight million nine hundred seventy-five thousand dollars ($8,975,000) to fund the non-federal share of payments to hospitals made under clause (A) of STEP FIVE of IC 12-15-15-1.5(c).

(iv) To fund the non-federal share of payments to hospitals made under clause (B) of STEP FIVE of IC 12-15-15-1.5(c).

(v) To fund the non-federal share of payments to hospitals made under clause (C) of STEP FIVE of IC 12-15-15-1.5(c).

(vi) To fund the non-federal share of disproportionate share payments to hospitals under IC 12-15-19-2.1.

(vii) If additional funds are available after making payments under items (i) through (vi), to fund other Medicaid supplemental payments for hospitals approved by the office and included in the state Medicaid plan.

SECTION 25. IC 12-15-20.7-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2. **(a)** For each state fiscal year **ending before July 1, 2005,** subject to section 3 of this chapter, the office shall make the payments identified in this section in the following order:

(1) First, payments under IC 12-15-15-9 and IC 12-15-15-9.5.

(2) Second, payments under clauses (A) and (B) of STEP FIVE of IC 12-15-15-1.5(b).

(3) Third, Medicaid inpatient payments for safety-net hospitals and Medicaid outpatient payments for safety-net hospitals.

(4) Fourth, payments under IC 12-15-15-1.1 and 12-15-15-1.3.

(5) Fifth, payments under IC 12-15-19-8 for municipal disproportionate share hospitals.

(6) Sixth, payments under IC 12-15-19-2.1 for disproportionate share hospitals.

(7) Seventh, payments under clause (C) of STEP FIVE of IC 12-15-15-1.5(b).

(b) For each state fiscal year ending after June 30, 2005, subject to section 3 of this chapter, the office shall make the payments identified in this section in the following order:

(1) First, the payment under IC 12-15-20-2(8)(G)(i).

(2) Second, payments under IC 12-15-15-1.1 and IC 12-15-15-1.3.

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(3) Third, payments under IC 12-15-19-8.

(4) Fourth, payments under IC 12-15-15-9 and IC 12-15-15-9.5.

(5) Fifth, payments under clause (A) of STEP FIVE of IC 12-15-15-1.5(c).

(6) Sixth, payments under clause (B) of STEP FIVE of IC 12-15-15-1.5(c).

(7) Seventh, payments under clause (C) of STEP FIVE of IC 12-15-15-1.5(c).

(8) Eighth, payments under clause (D) of STEP FIVE of IC 12-15-15-1.5(c).

(9) Ninth, payments under IC 12-15-19-2.1 for disproportionate share hospitals.

SECTION 26. IC 12-15-44 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]:

Chapter 44. Healthier Indiana Insurance Program

Sec. 1. (a) As used in this chapter, "custodial parent" means the individual with whom a child resides and who is related to the child in one (1) of the following manners:

(1) Legal or biological mother.

(2) Legal or biological father.

(3) A blood relative within the fifth degree of relation, including an individual who is related by half blood.

(4) Stepfather, stepmother, stepbrother, or stepsister.

(5) An individual who legally adopts a child or the child's parent, as well as relatives of the adoptive parents.

(6) Legal spouses of an individual described in this subsection.

(b) The term includes the following adults who do not live with the child:

(1) A legal or biological parent who has partial custody or visitation rights for the child.

(2) The spouse of a parent described in subdivision (1) who is living with the parent described in subdivision (1).

Sec. 2. As used in this chapter, "preventative care services" means care that is provided to an individual for the purpose of preventing disease, diagnosing disease, or promoting good health.

Sec. 3. As used in this chapter, "program" refers to the healthier Indiana insurance program established by IC 12-15-44-4.

Sec. 4. (a) The healthier Indiana insurance program is established.

(b) The office shall administer the program. The department of

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insurance and the office of the secretary shall provide oversight on the marketing practices of the program. The office shall establish standards for consumer protection and appeal procedures that must include the following:

(1) Quality of care standards.

(2) A uniform process for participants' grievances.

(3) Standardized reporting of provider performance, consumer experience, and cost.

(c) The following requirements apply to funds appropriated by the general assembly to the program:

(1) At least ninety percent (90%) must be used to fund payment for health care services.

(2) Not more than ten percent (10%) may be used to fund:

(A) administrative costs; and

(B) any profit derived from a contract entered into by a person to provide services for the program.

(d) The program must include the following in a manner and to the extent determined by the office:

(1) Mental health care services.

(2) Inpatient hospital services.

(3) Prescription drug coverage.

(4) Emergency room services.

(5) Physician office services.

(6) Diagnostic services.

(7) Outpatient services, including therapy services.

(8) Comprehensive disease management.

(9) Home health services, including case management.

(10) Urgent care center services.

(11) Preventive care services.

(12) Family planning services, including contraceptives and sexually transmitted disease testing, as described in federal Medicaid law.

(13) Hospice services.

(14) Substance abuse services.

(e) Mental health care services must include:

(1) full access to inpatient services and mental health drugs; and

(2) at least twelve (12) counseling visits and six (6) physician visits.

(f) The program must offer dental and vision services to individuals who pay an additional contribution as determined by the office but not to exceed five percent (5%) of the individual's

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income. The program must pay at least fifty percent (50%) of the cost of services but not to exceed the existing Medicaid rate for similar services.

(g) The program must comply with any health care coverage requirements required for an accident and sickness policy issued in the state. The program may not permit treatment limitations or financial requirements on the coverage of services for a mental illness or substance abuse if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.

Sec. 5. (a) An individual is eligible for the program if the individual meets the following requirements:

(1) The individual is at least eighteen (18) years of age and less than sixty-five (65) years of age.

(2) The individual is a United States citizen and has been a resident of Indiana for at least twelve (12) months.

(3) The individual has an annual household income of not more than two hundred percent (200%) of the federal income poverty level.

(4) The individual is not eligible for health insurance coverage through the individual's employer.

(5) The individual has not had health insurance coverage for at least six (6) months.

(b) The following individuals are not eligible for this program:

(1) An individual who participates in the federal Medicare program (42 U.S.C. 1395 et seq.).

(2) A pregnant woman for purposes of pregnancy related services.

(3) An individual who is eligible for the Medicaid program as a disabled person.

(c) An individual's participation in the program does not begin until the individual has made the initial contribution to the individual's health care account.

Sec. 6. (a) In order to participate in the program, an individual shall do the following:

(1) Apply for the program on a form prescribed by the office. The office may develop and allow a joint application for a household.

(2) If the individual is approved by the office to participate in the program, contribute to the individual's health care account at least one thousand one hundred dollars ($1,100) per year, but:

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(A) not more than two percent (2%) if the individual has an annual household income of not more than one hundred fifty percent (150%) of the federal income poverty level;

(B) not more than three percent (3%) if the individual has an annual household income of more than one hundred fifty percent (150%) of the federal income poverty level but not more than two hundred percent (200%) of the federal income poverty; or

(C) one thousand one hundred dollars ($1,100) per year less the individual's contributions to the Medicaid program under IC 12-15, the children's health insurance program under IC 12-17.6, or the Medicare program (42 U.S.C. 1395 et seq.), as determined by the office.

(b) The state shall contribute the difference into the individual's account if the individual's contribution required under subsection (a)(2)(A) is less than the required one thousand one hundred dollars ($1,100).

(c) If the individual does not make the individual's contributions to the program within sixty (60) days of the required payment, the individual may be terminated from participating in the program. The individual shall receive written notice before the individual is terminated from the program.

(d) After termination from the program under subsection (c), the individual may not reapply to participate in the program for three (3) months.

(e) Subject to appeal with the office, an individual may be held responsible under the program for receiving nonemergency services in an emergency room setting. This may include requiring the individual to pay for services received in the emergency room with money outside the individual's health care account. An individual is not responsible for payment for emergency services outside of the health care account for a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to:

(1) place an individual's health in serious jeopardy;

(2) result in serious impairment to the individual's bodily functions; or

(3) result in serious dysfunction of a bodily organ or part of the individual.

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Sec. 7. (a) A participant must have a health care account in which contributions are made by the participant, an employer, or the office.

(b) The minimum amount in the account is the amount contributed by the individual and the state as described in section 6 of this chapter.

(c) The account is to be used for paying the individual's deductible for health care services in the program.

(d) The individual may contribute to the individual's health care account through the following means:

(1) By the employer withholding or causing to be withheld from the participating employee's wages or salary, after taxes are taken out of the wages or salary, the participating employee's required share described in this chapter and distributed equally throughout the calendar year.

(2) By submitting the individual's required share to the office to deposit into the individual's account in a manner prescribed by the office.

(3) Any other means determined by the office.

(e) An employer may not contribute more than fifty percent (50%) of the individual's required share to the health care account.

Sec. 8. (a) The program must cover preventative care services, as determined by the office, for a participant of not more than five hundred dollars ($500) per year. This amount shall be paid by the state at no cost to the participant.

(b) The office shall provide a participant with a list of health care services that will qualify as preventative care services for the age, gender, and preexisting conditions of the participant. The office shall consult the federal Centers for Disease Control and Prevention for a list of recommended preventative care services.

Sec. 9. (a) The office shall determine the health care services covered under the program.

(b) The program is not an entitlement program, and the number of individuals who may participate in the program is dependent upon the funds appropriated for use for the plan.

Sec. 10. The program has the following per recipient coverage limitations:

(1) An annual individual maximum coverage limitation of three hundred thousand dollars ($300,000).

(2) A lifetime individual maximum coverage of one million dollars ($1,000,000).

Sec. 11. (a) An individual who is approved to participate in the

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program is eligible for a twelve (12) month period. Once the individual has been approved for participation, the individual may not be turned down for renewal into the program for the sole reason that the program has reached the maximum number of participants.

(b) If the individual chooses to renew participation in the program, the individual shall complete a renewal application, any necessary documentation, and submit the documentation and application on a form prescribed by the office to the office in order to continue participating in the program.

(c) If the individual chooses not to renew participation in the program, the individual may not reapply to participate in the program for at least three (3) months.

Sec. 12. (a) An insurer or health maintenance organization that has contracted with the office to provide health insurance for individuals under this program:

(1) bears the risk of the health insurance program;

(2) is responsible for the claim processing under the program;

(3) shall reimburse providers at a reimbursement rate of:

(A) at least the federal Medicare reimbursement rate for the service provided; or

(B) at a rate of one hundred thirty percent (130%) of the Medicaid reimbursement rate for a service that does not have a Medicare reimbursement rate; and

(4) may not deny coverage to an eligible individual who has been approved by the office to participate in the program, except if the maximum coverage rates are met as described in section 10 of this chapter.

(b) An insurer or a health maintenance organization that has contracted with the office to provide health insurance under the program shall also offer to provide the same health insurance to the following:

(1) An individual who has not been covered by a health care insurance policy in the previous six (6) months and who has an annual household income that is:

(A) not more than two hundred percent (200%) of the federal income poverty level but the individual is not eligible for the program because of the individual's income; however, standard underwriting principles must apply; or

(B) more than two hundred percent (200%) of the federal income poverty level.

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(2) An individual who is not eligible for the program because a slot is not available.

(3) The employees of an employer if:

(A) the employees have an annual household income that is more than two hundred percent (200%) of the federal income poverty level; and

(B) the employer:

(i) has not offered employees health care insurance in the previous six (6) months; and

(ii) pays at least fifty percent (50%) of the premium for the employer's employees.

The state does not provide funding for coverage provided under this subsection.

(c) An insurer or a health maintenance organization that has contracted with the office to provide health insurance under the program must incorporate cultural competency standards established by the office. The standards must include standards for non-English speaking, minority, and disabled populations.

Sec. 13. (a) A participant in the program has coverage for a period of twelve (12) months. If the participant would like to continue participating in the program, the participant must submit an application for renewal with the office as required in section 11 of this chapter.

(b) For an individual who has renewed their application and been accepted into the program, at the end of an individual's twelve (12) month program period, any money that is remaining in the individual's health care account must be used to reduce the individual's contributions for the subsequent program period. However, if the individual did not use the amount required for preventative services, the office's contribution in the account may not be used to reduce the individual's contributions.

(c) If an individual is no longer eligible for the program or is terminated from the program, the individual may withdraw the money that is remaining in the account that the individual contributed. The office shall determine the amount by prorating the remaining amount in the account with the amount contributed by the individual.

(d) Money remaining in the account at the end of the individual's twelve (12) month period that is not withdrawn as allowed under subsection (c) is forfeited by the individual and reverts back to the state for deposit in the healthier Indiana insurance trust fund.

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Sec. 14. (a) The healthier Indiana insurance trust fund is established for the following purposes:

(1) Administering a program created by the general assembly to provide health insurance for low income residents of the state under this chapter.

(2) Providing copayments, preventative care services, and premiums for individuals enrolled in the program.

(3) Funding tobacco use prevention and cessation programs and programs designed to promote the general health and well being of Indiana residents.

The fund is separate from the state general fund.

(b) The fund shall be administered by the office of the secretary of family and social services.

(c) The expenses of administering the fund shall be paid from money in the fund.

(d) The fund shall consist of the following:

(1) Cigarette tax revenues and tobacco products tax revenues designated by the general assembly to be part of the fund.

(2) Other funds designated by the general assembly to be part of the fund.

(3) Federal funds available for the purposes of the fund.

(4) Gifts or donations to the fund.

(e) The treasurer of state shall invest the money in the fund not currently needed to meet the obligations of the fund in the same manner as other public money may be invested.

(f) Money must be appropriated before funds are available for use.

(g) Money in the fund does not revert to the state general fund at the end of any fiscal year.

(h) The fund is considered a trust fund for purposes of IC 4-9.1-1-7. Money may not be transferred, assigned, or otherwise removed from the fund by the state board of finance, the budget agency, or any other state agency.

Sec. 15. (a) The office may not:

(1) enroll applicants;

(2) approve any contracts with vendors to provide services or administer the program;

(3) incur costs other than those necessary to study and plan for the implementation of the program; or

(4) create financial obligations for the state;

unless both of the conditions of subsection (b) are satisfied.

(b) The office may not take any action described in subsection

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(a) unless:

(1) there is a specific appropriation from the general assembly to implement the program; and

(2) after review by the budget committee, the budget agency approves an actuarial analysis that demonstrates sufficient funding is reasonably estimated to be available to operate the program for at least the following eight (8) years.

The actuarial analysis under subdivision (2) must clearly indicate the cost and revenue assumptions used in reaching the determination.

(c) The office may not operate the program in a way that would obligate the state to financial participation beyond the level of state appropriations authorized for this purpose.

(d) The office of the secretary may refer an individual who:

(1) has applied for health insurance from the program under section 12(b) of this chapter; and

(2) is at high risk of chronic disease;

to the program administered under IC 27-8-10.1.

Sec. 16. The office may adopt rules under IC 4-22-2 necessary to implement this chapter. The office may adopt emergency rules under IC 4-22-2-37.1 to implement the program on an emergency basis.

Sec. 17. The office shall promote the program and provide information to potential eligible individuals who live in medically underserved rural areas of the state.

Sec. 18. The office shall participate in a health information technology program that focuses on ways to reduce medical errors and reduce costs in the program.

Sec. 19. The office may develop a health insurance premium assistance program for individuals who have an annual household income of at least two hundred percent (200%) of the federal income poverty level and are eligible for insurance through the individual's employer but can not afford the health insurance premiums. The program established under this section must contain similar eligibility requirements as the program and include a health savings account as a component. An individual's contribution under this section may not exceed two percent (2%) of the individual's annual income.

Sec. 20. (a) Contingent on approval and funding by the United States Department of Health and Human Services and a sufficient appropriation, the office shall develop a health care account program for individuals who are at least eighteen (18) years of age

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and have an annual household income of at least two hundred percent (200%) but not more than three hundred percent (300%) of the federal income poverty level.

(b) The office may not implement a program under this section without approval from the general assembly.

SECTION 27. IC 12-16-7.5-4.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 4.5. (a) Not later than October 31 following the end of each state fiscal year, the division shall:

(1) calculate for each county the total amount of payable claims submitted to the division during the state fiscal year attributed to:

(A) patients who were residents of the county; and

(B) patients:

(i) who were not residents of Indiana;

(ii) whose state of residence could not be determined by the division; and

(iii) who were residents of Indiana but whose county of residence in Indiana could not be determined by the division;

and whose medical condition that necessitated the care or service occurred in the county;

(2) notify each county of the amount of payable claims attributed to the county under the calculation made under subdivision (1); and

(3) with respect to payable claims attributed to a county under subdivision (1):

(A) calculate the total amount of payable claims submitted during the state fiscal year for:

(i) each hospital;

(ii) each physician; and

(iii) each transportation provider; and

(B) determine the amount of each payable claim for each hospital, physician, and transportation provider listed in clause (A).

(b) Before November 1 following the end of a state fiscal year, the division shall allocate the funds transferred from a county's hospital care for the indigent fund to the state hospital care for the indigent fund under IC 12-16-14 during or for the state fiscal year as required under the following STEPS:

STEP ONE: Determine the total amount of funds transferred from a county's hospital care for the indigent fund by the county to the state hospital care for the indigent fund under IC 12-16-14 during

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or for the state fiscal year.

STEP TWO: Of the total amount of payable claims submitted to the division during the state fiscal year attributed to the county under subsection (a), determine the amount of total hospital payable claims, total physician payable claims, and total transportation provider payable claims. Of the amounts determined for physicians and transportation providers, calculate the sum of those amounts as a percentage of an amount equal to the sum of the total payable physician claims and total payable transportation provider claims attributed to all the counties submitted to the division during the state fiscal year.

STEP THREE: Multiply three million dollars ($3,000,000) by the percentage calculated under STEP TWO.

STEP FOUR: Transfer to the Medicaid indigent care trust fund for purposes of IC 12-15-20-2(8)(D) **or IC 12-15-20-2(8)(G)** an amount equal to the amount calculated under STEP ONE, minus an amount equal to the amount calculated under STEP THREE.

STEP FIVE: The division shall retain an amount equal to the amount remaining in the state hospital care for the indigent fund after the transfer in STEP FOUR for purposes of making payments under section 5 of this chapter.

(c) The costs of administering the hospital care for the indigent program, including the processing of claims, shall be paid from the funds transferred to the state hospital care for the indigent fund.

SECTION 28. IC 12-16-14-3, AS AMENDED BY P.L.246-2005, SECTION 111, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 3. ~~(a) For purposes of this section, "payable claim" has the meaning set forth in IC 12-16-7.5-2.5(b)(1).~~

~~(b)~~ **(a)** For taxes first due and payable in 2003, each county shall impose a hospital care for the indigent property tax levy equal to the product of:

(1) the county's hospital care for the indigent property tax levy for taxes first due and payable in 2002; multiplied by

(2) the county's assessed value growth quotient determined under IC 6-1.1-18.5-2 for taxes first due and payable in 2003.

~~(c)~~ **(b)** For taxes first due and payable in 2004, ~~2005, 2006, 2007, and 2008,~~ **and each year thereafter,** each county shall impose a hospital care for the indigent property tax levy equal to the ~~product of:~~ **hospital care for the indigent program property tax levy for taxes first due and payable in the preceding calendar year.**

~~(1) the county's hospital care for the indigent property tax levy for taxes first due and payable in the preceding year; multiplied by~~

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~~(2) the assessed value growth quotient determined in the last STEP of the following STEPS:~~

~~STEP ONE: Determine the three (3) calendar years that most immediately precede the ensuing calendar year and in which a statewide general reassessment of real property does not first become effective.~~

~~STEP TWO: Compute separately, for each of the calendar years determined in STEP ONE, the quotient (rounded to the nearest ten-thousandth) of the county's total assessed value of all taxable property in the particular calendar year, divided by the county's total assessed value of all taxable property in the calendar year immediately preceding the particular calendar year.~~

~~STEP THREE: Divide the sum of the three (3) quotients computed in STEP TWO by three (3).~~

~~(d) Except as provided in subsection (e):~~

~~(1) for taxes first due and payable in 2009, each county shall impose a hospital care for the indigent property tax levy equal to the average of the annual amount of payable claims attributed to the county under IC 12-16-7.5-4.5 during the state fiscal years beginning:~~

~~(A) July 1, 2005;~~

~~(B) July 1, 2006; and~~

~~(C) July 1, 2007; and~~

~~(2) for all subsequent annual levies under this section, the average annual amount of payable claims attributed to the county under IC 12-16-7.5-4.5 during the three (3) most recently completed state fiscal years.~~

~~(e) A county may not impose an annual levy under subsection (d) in an amount greater than the product of:~~

~~(1) The greater of:~~

~~(A) the county's hospital care for the indigent property tax levy for taxes first due and payable in 2008; or~~

~~(B) the amount of the county's maximum hospital care for the indigent property tax levy determined under this subsection for taxes first due and payable in the immediately preceding year; multiplied by~~

~~(2) the assessed value growth quotient determined in the last STEP of the following STEPS:~~

~~STEP ONE: Determine the three (3) calendar years that most immediately precede the ensuing calendar year and in which a statewide general reassessment of real property does not first become effective.~~

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~~STEP TWO: Compute separately, for each of the calendar years determined in STEP ONE, the quotient (rounded to the nearest ten-thousandth) of the county's total assessed value of all taxable property in the particular calendar year, divided by the county's total assessed value of all taxable property in the calendar year immediately preceding the particular calendar year.~~

~~STEP THREE: Divide the sum of the three (3) quotients computed in STEP TWO by three (3).~~

SECTION 29. IC 12-17.6-3-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2. (a) To be eligible to enroll in the program, a child must meet the following requirements:

(1) The child is less than nineteen (19) years of age.

(2) The child is a member of a family with an annual income of:

(A) more than one hundred fifty percent (150%); and

(B) not more than ~~two~~ **three** hundred percent ~~(200%),~~ **(300%);**

of the federal income poverty level.

(3) The child is a resident of Indiana.

(4) The child meets all eligibility requirements under Title XXI of the federal Social Security Act.

(5) The child's family agrees to pay any cost sharing amounts required by the office.

(b) The office may adjust eligibility requirements based on available program resources under rules adopted under IC 4-22-2.

SECTION 30. IC 12-17.6-3-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 3. (a) Subject to subsection (b), a child who is eligible for the program shall receive services from the program until the earlier of the following:

(1) The ~~child becomes financially ineligible.~~ **end of a period of twelve (12) consecutive months following the determination of the child's eligibility for the program.**

(2) The child becomes nineteen (19) years of age.

(b) Subsection (a) applies only if the child and the child's family comply with enrollment requirements.

SECTION 31. IC 16-45-4 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]:

Chapter 4. Rural Health Care Pilot Program Support Fund

Sec. 1. As used in this chapter, "office" means the office of technology established by IC 4-13.1-2-1.

Sec. 2. As used in this chapter, "pilot program" refers to the rural health care pilot program established by the Federal

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Communications Commission under 47 U.S.C. 254(h)(A)(2) to provide federal funding to support the construction of state or regional broadband networks and the services provided over those networks.

Sec. 3. (a) The rural health care pilot program support fund is established for the purpose of making grants to Indiana health care providers who participate in the pilot program. The fund shall be administered by the office.

(b) The expenses of administering the fund shall be paid from the money in the fund.

(c) The fund consists of:

(1) money appropriated or otherwise designated or dedicated by the general assembly; and

(2) gifts, grants, and bequests.

(d) Notwithstanding IC 5-13, the treasurer of state shall invest the money in the fund not currently needed to meet the obligations of the fund under IC 5-10.3-5. The treasurer of state may contract with investment management professionals, investment advisers, and legal counsel to assist in the management of the fund and may pay the state expenses incurred under those contracts.

(e) Money in the fund at the end of a state fiscal year does not revert to the state general fund.

Sec. 4. (a) The office must use money in the fund to make grants to health care providers who participate in the pilot program. A health care provider that receives a grant under this chapter must use the grant money to make the local match required as a condition of the provider's participation in the pilot program.

(b) The office may:

(1) prescribe grant application forms;

(2) establish grant application procedures; and

(3) take any other action necessary to implement this chapter.

SECTION 32. IC 16-18-2-163 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 163. (a) "Health care provider", for purposes of IC 16-21 and IC 16-41, means any of the following:

(1) An individual, a partnership, a corporation, a professional corporation, a facility, or an institution licensed or legally authorized by this state to provide health care or professional services as a licensed physician, a psychiatric hospital, a hospital, a health facility, an emergency ambulance service (IC 16-31-3), a dentist, a registered or licensed practical nurse, a midwife, an optometrist, a pharmacist, a podiatrist, a chiropractor, a physical

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therapist, a respiratory care practitioner, an occupational therapist, a psychologist, a paramedic, an emergency medical technician, an emergency medical technician-basic advanced, an emergency medical technician-intermediate, or a person who is an officer, employee, or agent of the individual, partnership, corporation, professional corporation, facility, or institution acting in the course and scope of the person's employment.

(2) A college, university, or junior college that provides health care to a student, a faculty member, or an employee, and the governing board or a person who is an officer, employee, or agent of the college, university, or junior college acting in the course and scope of the person's employment.

(3) A blood bank, community mental health center, community mental retardation center, community health center, or migrant health center.

(4) A home health agency (as defined in IC 16-27-1-2).

(5) A health maintenance organization (as defined in IC 27-13-1-19).

(6) A health care organization whose members, shareholders, or partners are health care providers under subdivision (1).

(7) A corporation, partnership, or professional corporation not otherwise qualified under this subsection that:

(A) provides health care as one (1) of the corporation's, partnership's, or professional corporation's functions;

(B) is organized or registered under state law; and

(C) is determined to be eligible for coverage as a health care provider under IC 34-18 for the corporation's, partnership's, or professional corporation's health care function.

Coverage for a health care provider qualified under this subdivision is limited to the health care provider's health care functions and does not extend to other causes of action.

(b) "Health care provider", for purposes of IC 16-35, has the meaning set forth in subsection (a). However, for purposes of IC 16-35, the term also includes a health facility (as defined in section 167 of this chapter).

(c) "Health care provider", for purposes of IC 16-36-5, means an individual licensed or authorized by this state to provide health care or professional services as:

(1) a licensed physician;

(2) a registered nurse;

(3) a licensed practical nurse;

(4) an advanced practice nurse;

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(5) a licensed nurse midwife;
(6) a paramedic;
(7) an emergency medical technician;
(8) an emergency medical technician-basic advanced;
(9) an emergency medical technician-intermediate; or
(10) a first responder, as defined under IC 16-18-2-131.

The term includes an individual who is an employee or agent of a health care provider acting in the course and scope of the individual's employment.

(d) "Health care provider", for purposes of IC 16-40-4, means any of the following:

(1) An individual, a partnership, a corporation, a professional corporation, a facility, or an institution licensed or authorized by the state to provide health care or professional services as a licensed physician, a psychiatric hospital, a hospital, a health facility, an emergency ambulance service (IC 16-31-3), an ambulatory outpatient surgical center, a dentist, an optometrist, a pharmacist, a podiatrist, a chiropractor, a psychologist, or a person who is an officer, employee, or agent of the individual, partnership, corporation, professional corporation, facility, or institution acting in the course and scope of the person's employment.

(2) A blood bank, laboratory, community mental health center, community mental retardation center, community health center, or migrant health center.

(3) A home health agency (as defined in IC 16-27-1-2).

(4) A health maintenance organization (as defined in IC 27-13-1-19).

(5) A health care organization whose members, shareholders, or partners are health care providers under subdivision (1).

(6) A corporation, partnership, or professional corporation not otherwise specified in this subsection that:

(A) provides health care as one (1) of the corporation's, partnership's, or professional corporation's functions;
(B) is organized or registered under state law; and
(C) is determined to be eligible for coverage as a health care provider under IC 34-18 for the corporation's, partnership's, or professional corporation's health care function.

(7) A person that is designated to maintain the records of a person described in subdivisions (1) through (6).

(e) "Health care provider", for purposes of IC 16-45-4, has the meaning set forth in 47 CFR 54.601(a).

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SECTION 33. IC 20-26-5-4, AS AMENDED BY P.L.168-2006, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 4. In carrying out the school purposes of a school corporation, the governing body acting on the school corporation's behalf has the following specific powers:

(1) In the name of the school corporation, to sue and be sued and to enter into contracts in matters permitted by applicable law.

(2) To take charge of, manage, and conduct the educational affairs of the school corporation and to establish, locate, and provide the necessary schools, school libraries, other libraries where permitted by law, other buildings, facilities, property, and equipment.

(3) To appropriate from the school corporation's general fund an amount, not to exceed the greater of three thousand dollars ($3,000) per budget year or one dollar ($1) per pupil, not to exceed twelve thousand five hundred dollars ($12,500), based on the school corporation's previous year's ADM, to promote the best interests of the school corporation through:

(A) the purchase of meals, decorations, memorabilia, or awards;

(B) provision for expenses incurred in interviewing job applicants; or

(C) developing relations with other governmental units.

(4) To:

(A) Acquire, construct, erect, maintain, hold, and contract for construction, erection, or maintenance of real estate, real estate improvements, or an interest in real estate or real estate improvements, as the governing body considers necessary for school purposes, including buildings, parts of buildings, additions to buildings, rooms, gymnasiums, auditoriums, playgrounds, playing and athletic fields, facilities for physical training, buildings for administrative, office, warehouse, repair activities, or housing school owned buses, landscaping, walks, drives, parking areas, roadways, easements and facilities for power, sewer, water, roadway, access, storm and surface water, drinking water, gas, electricity, other utilities and similar purposes, by purchase, either outright for cash (or under conditional sales or purchase money contracts providing for a retention of a security interest by the seller until payment is made or by notes where the contract, security retention, or note is permitted by applicable law), by exchange, by gift, by devise, by eminent domain, by lease with or without option to

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purchase, or by lease under IC 20-47-2, IC 20-47-3, or IC 20-47-5.

(B) Repair, remodel, remove, or demolish, or to contract for the repair, remodeling, removal, or demolition of the real estate, real estate improvements, or interest in the real estate or real estate improvements, as the governing body considers necessary for school purposes.

(C) Provide for conservation measures through utility efficiency programs or under a guaranteed savings contract as described in IC 36-1-12.5.

(5) To acquire personal property or an interest in personal property as the governing body considers necessary for school purposes, including buses, motor vehicles, equipment, apparatus, appliances, books, furniture, and supplies, either by cash purchase or under conditional sales or purchase money contracts providing for a security interest by the seller until payment is made or by notes where the contract, security, retention, or note is permitted by applicable law, by gift, by devise, by loan, or by lease with or without option to purchase and to repair, remodel, remove, relocate, and demolish the personal property. All purchases and contracts specified under the powers authorized under subdivision (4) and this subdivision are subject solely to applicable law relating to purchases and contracting by municipal corporations in general and to the supervisory control of state agencies as provided in section 6 of this chapter.

(6) To sell or exchange real or personal property or interest in real or personal property that, in the opinion of the governing body, is not necessary for school purposes, in accordance with IC 20-26-7, to demolish or otherwise dispose of the property if, in the opinion of the governing body, the property is not necessary for school purposes and is worthless, and to pay the expenses for the demolition or disposition.

(7) To lease any school property for a rental that the governing body considers reasonable or to permit the free use of school property for:

(A) civic or public purposes; or

(B) the operation of a school age child care program for children who are at least five (5) years of age and less than fifteen (15) years of age that operates before or after the school day, or both, and during periods when school is not in session;

if the property is not needed for school purposes. Under this subdivision, the governing body may enter into a long term lease

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with a nonprofit corporation, community service organization, or other governmental entity, if the corporation, organization, or other governmental entity will use the property to be leased for civic or public purposes or for a school age child care program. However, if payment for the property subject to a long term lease is made from money in the school corporation's debt service fund, all proceeds from the long term lease must be deposited in the school corporation's debt service fund so long as payment for the property has not been made. The governing body may, at the governing body's option, use the procedure specified in IC 36-1-11-10 in leasing property under this subdivision.

(8) To:

(A) Employ, contract for, and discharge superintendents, supervisors, principals, teachers, librarians, athletic coaches (whether or not they are otherwise employed by the school corporation and whether or not they are licensed under IC 20-28-5), business managers, superintendents of buildings and grounds, janitors, engineers, architects, physicians, dentists, nurses, accountants, teacher aides performing noninstructional duties, educational and other professional consultants, data processing and computer service for school purposes, including the making of schedules, the keeping and analyzing of grades and other student data, the keeping and preparing of warrants, payroll, and similar data where approved by the state board of accounts as provided below, and other personnel or services as the governing body considers necessary for school purposes.

(B) Fix and pay the salaries and compensation of persons and services described in this subdivision.

(C) Classify persons or services described in this subdivision and to adopt schedules of salaries or compensation.

(D) Determine the number of the persons or the amount of the services employed or contracted for as provided in this subdivision.

(E) Determine the nature and extent of the duties of the persons described in this subdivision.

The compensation, terms of employment, and discharge of teachers are, however, subject to and governed by the laws relating to employment, contracting, compensation, and discharge of teachers. The compensation, terms of employment, and discharge of bus drivers are subject to and governed by laws relating to employment, contracting, compensation, and discharge

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of bus drivers. The forms and procedures relating to the use of computer and data processing equipment in handling the financial affairs of the school corporation must be submitted to the state board of accounts for approval so that the services are used by the school corporation when the governing body determines that it is in the best interest of the school corporation while at the same time providing reasonable accountability for the funds expended.

(9) Notwithstanding the appropriation limitation in subdivision (3), when the governing body by resolution considers a trip by an employee of the school corporation or by a member of the governing body to be in the interest of the school corporation, including attending meetings, conferences, or examining equipment, buildings, and installation in other areas, to permit the employee to be absent in connection with the trip without any loss in pay and to reimburse the employee or the member the employee's or member's reasonable lodging and meal expenses and necessary transportation expenses. To pay teaching personnel for time spent in sponsoring and working with school related trips or activities.

(10) To transport children to and from school, when in the opinion of the governing body the transportation is necessary, including considerations for the safety of the children and without regard to the distance the children live from the school. The transportation must be otherwise in accordance with applicable law.

(11) To provide a lunch program for a part or all of the students attending the schools of the school corporation, including the establishment of kitchens, kitchen facilities, kitchen equipment, lunch rooms, the hiring of the necessary personnel to operate the lunch program, and the purchase of material and supplies for the lunch program, charging students for the operational costs of the lunch program, fixing the price per meal or per food item. To operate the lunch program as an extracurricular activity, subject to the supervision of the governing body. To participate in a surplus commodity or lunch aid program.

(12) To purchase textbooks, to furnish textbooks without cost or to rent textbooks to students, to participate in a textbook aid program, all in accordance with applicable law.

(13) To accept students transferred from other school corporations and to transfer students to other school corporations in accordance with applicable law.

(14) To make budgets, to appropriate funds, and to disburse the

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money of the school corporation in accordance with applicable law. To borrow money against current tax collections and otherwise to borrow money, in accordance with IC 20-48-1.

(15) To purchase insurance or to establish and maintain a program of self-insurance relating to the liability of the school corporation or the school corporation's employees in connection with motor vehicles or property and for additional coverage to the extent permitted and in accordance with IC 34-13-3-20. To purchase additional insurance or to establish and maintain a program of self-insurance protecting the school corporation and members of the governing body, employees, contractors, or agents of the school corporation from liability, risk, accident, or loss related to school property, school contract, school or school related activity, including the purchase of insurance or the establishment and maintenance of a self-insurance program protecting persons described in this subdivision against false imprisonment, false arrest, libel, or slander for acts committed in the course of the persons' employment, protecting the school corporation for fire and extended coverage and other casualty risks to the extent of replacement cost, loss of use, and other insurable risks relating to property owned, leased, or held by the school corporation. To:

(A) participate in a state employee health plan under IC 5-10-8-6.6;

(B) purchase insurance; ~~or~~

(C) establish and maintain a program of self-insurance; **or**

(D) participate in a state employee health plan under IC 5-10-8-6.7;

to benefit school corporation employees, including accident, sickness, health, or dental coverage, provided that a plan of self-insurance must include an aggregate stop-loss provision.

(16) To make all applications, to enter into all contracts, and to sign all documents necessary for the receipt of aid, money, or property from the state, the federal government, or from any other source.

(17) To defend a member of the governing body or any employee of the school corporation in any suit arising out of the performance of the member's or employee's duties for or employment with, the school corporation, if the governing body by resolution determined that the action was taken in good faith. To save any member or employee harmless from any liability, cost, or damage in connection with the performance, including the

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payment of legal fees, except where the liability, cost, or damage is predicated on or arises out of the bad faith of the member or employee, or is a claim or judgment based on the member's or employee's malfeasance in office or employment.

(18) To prepare, make, enforce, amend, or repeal rules, regulations, and procedures:

(A) for the government and management of the schools, property, facilities, and activities of the school corporation, the school corporation's agents, employees, and pupils and for the operation of the governing body; and

(B) that may be designated by an appropriate title such as "policy handbook", "bylaws", or "rules and regulations".

(19) To ratify and approve any action taken by a member of the governing body, an officer of the governing body, or an employee of the school corporation after the action is taken, if the action could have been approved in advance, and in connection with the action to pay the expense or compensation permitted under IC 20-26-1 through IC 20-26-5, IC 20-26-7, IC 20-40-12, and IC 20-48-1 or any other law.

(20) To exercise any other power and make any expenditure in carrying out the governing body's general powers and purposes provided in this chapter or in carrying out the powers delineated in this section which is reasonable from a business or educational standpoint in carrying out school purposes of the school corporation, including the acquisition of property or the employment or contracting for services, even though the power or expenditure is not specifically set out in this chapter. The specific powers set out in this section do not limit the general grant of powers provided in this chapter except where a limitation is set out in IC 20-26-1 through IC 20-26-5, IC 20-26-7, IC 20-40-12, and IC 20-48-1 by specific language or by reference to other law.

SECTION 34. IC 27-8-5-2, AS AMENDED BY P.L.125-2005, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2. (a) No individual policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless it complies with each of the following:

(1) The entire money and other considerations for the policy are expressed in the policy.

(2) The time at which the insurance takes effect and terminates is expressed in the policy.

(3) The policy purports to insure only one (1) person, except that a policy ~~may~~ **must** insure, originally or by subsequent

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amendment, upon the application of any member of a family who shall be deemed the policyholder and who is at least eighteen (18) years of age, any two (2) or more eligible members of that family, including husband, wife, dependent children, or any children ~~under a specified age, which shall not exceed nineteen (19)~~ **who are less than twenty-four (24)** years **of age,** and any other person dependent upon the policyholder.

(4) The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in lightface type of a style in general use, the size of which shall be uniform and not less than ten point with a lower-case unspaced alphabet length not less than one hundred and twenty point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description if any, and captions and subcaptions).

(5) The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in section 3 of this chapter, are printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "EXCEPTIONS", or "EXCEPTIONS AND REDUCTIONS", provided that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies.

(6) Each such form of the policy, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page of the policy.

(7) The policy contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of or reference to a statement of rates or classification of risks, or short-rate table filed with the commissioner.

(8) If an individual accident and sickness insurance policy or hospital service plan contract or medical service plan contract provides that hospital or medical expense coverage of a dependent child terminates upon attainment of the limiting age for dependent children specified in such policy or contract, the policy or contract must also provide that attainment of such limiting age does not operate to terminate the hospital and medical coverage

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of such child while the child is and continues to be both:

(A) incapable of self-sustaining employment by reason of mental retardation or mental or physical disability; and

(B) chiefly dependent upon the policyholder for support and maintenance.

Proof of such incapacity and dependency must be furnished to the insurer by the policyholder within thirty-one (31) days of the child's attainment of the limiting age. The insurer may require at reasonable intervals during the two (2) years following the child's attainment of the limiting age subsequent proof of the child's disability and dependency. After such two (2) year period, the insurer may require subsequent proof not more than once each year. The foregoing provision shall not require an insurer to insure a dependent who is a mentally retarded or mentally or physically disabled child where such dependent does not satisfy the conditions of the policy provisions as may be stated in the policy or contract required for coverage thereunder to take effect. In any such case the terms of the policy or contract shall apply with regard to the coverage or exclusion from coverage of such dependent. This subsection applies only to policies or contracts delivered or issued for delivery in this state more than one hundred twenty (120) days after August 18, 1969.

(b) If any policy is issued by an insurer domiciled in this state for delivery to a person residing in another state, and if the official having responsibility for the administration of the insurance laws of such other state shall have advised the commissioner that any such policy is not subject to approval or disapproval by such official, the commissioner may by ruling require that such policy meet the standards set forth in subsection (a) and in section 3 of this chapter.

(c) An insurer may issue a policy described in this section in electronic or paper form. However, the insurer shall:

(1) inform the insured that the insured may request the policy in paper form; and

(2) issue the policy in paper form upon the request of the insured.

SECTION 35. IC 27-8-5-16 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 16. Except as provided in sections 17 and 24 of this chapter, no policy of group accident and sickness insurance may be delivered or issued for delivery to a group that has a legal situs in Indiana unless it conforms to one (1) of the following descriptions:

(1) A policy issued to an employer or to the trustees of a fund established by an employer (which employer or trustees must be

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deemed the policyholder) to insure employees of the employer for the benefit of persons other than the employer, subject to the following requirements:

(A) The employees eligible for insurance under the policy must be all of the employees of the employer, or all of any class or classes of employees. The policy may provide that the term "employees" includes the employees of one (1) or more subsidiary corporations and the employees, individual proprietors, members, and partners of one (1) or more affiliated corporations, proprietorships, limited liability companies, or partnerships if the business of the employer and of the affiliated corporations, proprietorships, limited liability companies, or partnerships is under common control. The policy may provide that the term "employees" includes retired employees, former employees, and directors of a corporate employer. A policy issued to insure the employees of a public body may provide that the term "employees" includes elected or appointed officials.

(B) The premium for the policy must be paid either from the employer's funds, from funds contributed by the insured employees, or from both sources of funds. Except as provided in clause (C), a policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, except those who reject the coverage in writing.

(C) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(2) A policy issued to a creditor or its parent holding company or to a trustee or trustees or agent designated by two (2) or more creditors (which creditor, holding company, affiliate, trustee, trustees, or agent must be deemed the policyholder) to insure debtors of the creditor, or creditors, subject to the following requirements:

(A) The debtors eligible for insurance under the policy must be all of the debtors of the creditor or creditors, or all of any class or classes of debtors. The policy may provide that the term "debtors" includes:

(i) borrowers of money or purchasers or lessees of goods, services, or property for which payment is arranged through a credit transaction;

(ii) the debtors of one (1) or more subsidiary corporations;

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and

(iii) the debtors of one (1) or more affiliated corporations, proprietorships, limited liability companies, or partnerships if the business of the policyholder and of the affiliated corporations, proprietorships, limited liability companies, or partnerships is under common control.

(B) The premium for the policy must be paid either from the creditor's funds, from charges collected from the insured debtors, or from both sources of funds. Except as provided in clause (C), a policy on which no part of the premium is to be derived from the funds contributed by insured debtors specifically for their insurance must insure all eligible debtors.

(C) An insurer may exclude any debtors as to whom evidence of individual insurability is not satisfactory to the insurer.

(D) The amount of the insurance payable with respect to any indebtedness may not exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor. The insurer may exclude any payments that are delinquent on the date the debtor becomes disabled as defined in the policy.

(E) The insurance may be payable to the creditor or any successor to the right, title, and interest of the creditor. Each payment under this clause must reduce or extinguish the unpaid indebtedness of the debtor to the extent of the payment, and any excess of the insurance must be payable to the insured or the estate of the insured.

(F) Notwithstanding clauses (A) through (E), insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment on a nondecreasing or level term plan, and insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan.

(3) A policy issued to a labor union or similar employee organization (which must be deemed to be the policyholder) to insure members of the union or organization for the benefit of persons other than the union or organization or any of its officials, representatives, or agents, subject to the following requirements:

(A) The members eligible for insurance under the policy must be all of the members of the union or organization, or all of any class or classes of members.

(B) The premium for the policy must be paid either from funds of the union or organization, from funds contributed by the

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insured members specifically for their insurance, or from both sources of funds. Except as provided in clause (C), a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, except those who reject the coverage in writing.

(C) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(4) A policy issued to a trust or to one (1) or more trustees of a fund established or adopted by two (2) or more employers, or by one (1) or more labor unions or similar employee organizations, or by one (1) or more employers and one (1) or more labor unions or similar employee organizations (which trust or trustees must be deemed the policyholder) to insure employees of the employers or members of the unions or organizations for the benefit of persons other than the employers or the unions or organizations, subject to the following requirements:

(A) The persons eligible for insurance must be all of the employees of the employers or all of the members of the unions or organizations, or all of any class or classes of employees or members. The policy may provide that the term "employees" includes the employees of one (1) or more subsidiary corporations and the employees, individual proprietors, and partners of one (1) or more affiliated corporations, proprietorships, limited liability companies, or partnerships if the business of the employer and of the affiliated corporations, proprietorships, limited liability companies, or partnerships is under common control. The policy may provide that the term "employees" includes retired employees, former employees, and directors of a corporate employer. The policy may provide that the term "employees" includes the trustees or their employees, or both, if their duties are principally connected with the trusteeship.

(B) The premium for the policy must be paid from funds contributed by the employer or employers of the insured persons, by the union or unions or similar employee organizations, or by both, or from funds contributed by the insured persons or from both the insured persons and one (1) or more employers, unions, or similar employee organizations. Except as provided in clause (C), a policy on which no part of the premium is to be derived from funds contributed by the

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insured persons specifically for their insurance must insure all eligible persons, except those who reject the coverage in writing.

(C) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(5) A policy issued to an association or to a trust or to one (1) or more trustees of a fund established, created, or maintained for the benefit of members of one (1) or more associations. The association or associations must have at the outset a minimum of one hundred (100) persons, must have been organized and maintained in good faith for purposes other than that of obtaining insurance, must have been in active existence for at least one (1) year, and must have a constitution and bylaws that provide that the association or associations hold regular meetings not less than annually to further purposes of the members, that, except for credit unions, the association or associations collect dues or solicit contributions from members, and that the members have voting privileges and representation on the governing board and committees. The policy must be subject to the following requirements:

(A) The policy may insure members or employees of the association or associations, employees of members, one (1) or more of the preceding, or all of any class or classes of members, employees, or employees of members for the benefit of persons other than the employee's employer.

(B) The premium for the policy must be paid from funds contributed by the association or associations, by employer members, or by both, from funds contributed by the covered persons, or from both the covered persons and the association, associations, or employer members.

(C) Except as provided in clause (D), a policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for the insurance must insure all eligible persons, except those who reject such coverage in writing.

(D) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(6) A policy issued to a credit union, or to one (1) or more trustees or an agent designated by two (2) or more credit unions (which credit union, trustee, trustees, or agent must be deemed the

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policyholder) to insure members of the credit union or credit unions for the benefit of persons other than the credit union or credit unions, trustee, trustees, or agent, or any of their officials, subject to the following requirements:

(A) The members eligible for insurance must be all of the members of the credit union or credit unions, or all of any class or classes of members.

(B) The premium for the policy shall be paid by the policyholder from the credit union's funds and, except as provided in clause (C), must insure all eligible members.

(C) An insurer may exclude or limit the coverage on any member as to whom evidence of individual insurability is not satisfactory to the insurer.

(7) A policy issued to cover persons in a group specifically described by another law of Indiana as a group that may be covered for group life insurance. The provisions of the group life insurance law relating to eligibility and evidence of insurability apply to a group health policy to which this subdivision applies.

(8) A policy issued to a trustee or agent designated by two (2) or more small employers (as defined in IC 27-8-15-14) as determined by the commissioner under rules adopted under IC 4-22-2.

SECTION 36. IC 27-8-5-17 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 17. (a) A group accident and sickness insurance policy shall not be delivered or issued for delivery in Indiana to a group that is not described in section 16(1)(A), 16(2)(A), 16(3)(A), 16(4)(A), 16(5)(A), 16(6)(A), ~~or~~ 16(7), **or 16(8)** of this chapter unless the commissioner finds that:

(1) the issuance of the policy is not contrary to the best interest of the public;

(2) the issuance of the policy would result in economies of acquisition or administration; and

(3) the benefits of the policy are reasonable in relation to the premiums charged.

(b) Except as otherwise provided in this chapter, an insurer may exclude or limit the coverage under a policy described in subsection (a) on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

SECTION 37. IC 27-8-5-28 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 28. A policy of accident and sickness insurance may not be issued, delivered, amended, or renewed unless the policy**

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provides for coverage of a child of the policyholder or certificate holder, upon request of the policyholder or certificate holder, until the date that the child becomes twenty-four (24) years of age.

SECTION 38. IC 27-8-10.1 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]:

Chapter 10.1. High Risk Hoosiers Under the Healthier Indiana Insurance Program

Sec. 1. As used in this chapter, "association" means the Indiana comprehensive health insurance association established by IC 27-8-10-2.1.

Sec. 2. As used in this chapter, "covered individual" means an individual entitled to coverage under the program.

Sec. 3. As used in this chapter, "program" refers to the healthier Indiana insurance program established by IC 12-15-44-4.

Sec. 4. (a) The association shall administer the program for individuals who are referred to the association by the office of the secretary of family and social services.

(b) Coverage under the program is separate from the coverage provided under IC 27-8-10.

(c) The following apply to the administration of the program under this chapter:

(1) Only individuals referred by the office of the secretary of family and social services are eligible for program coverage administered under this chapter.

(2) Program coverage administered under this chapter must provide medical management services.

(d) A covered individual shall participate in medical management services provided under this chapter.

SECTION 39. IC 27-13-7-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 3. (a) A contract referred to in section 1 of this chapter must clearly state the following:

(1) The name and address of the health maintenance organization.

(2) Eligibility requirements.

(3) Benefits and services within the service area.

(4) Emergency care benefits and services.

(5) Any out-of-area benefits and services.

(6) Copayments, deductibles, and other out-of-pocket costs.

(7) Limitations and exclusions.

(8) Enrollee termination provisions.

(9) Any enrollee reinstatement provisions.

(10) Claims procedures.

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(11) Enrollee grievance procedures.
(12) Continuation of coverage provisions.
(13) Conversion provisions.
(14) Extension of benefit provisions.
(15) Coordination of benefit provisions.
(16) Any subrogation provisions.
(17) A description of the service area.
(18) The entire contract provisions.
(19) The term of the coverage provided by the contract.
(20) Any right of cancellation of the group or individual contract holder.
(21) Right of renewal provisions.
(22) Provisions regarding reinstatement of a group or an individual contract holder.
(23) Grace period provisions.
(24) A provision on conformity with state law.
(25) A provision or provisions that comply with the:
(A) guaranteed renewability; and
(B) group portability;
requirements of the federal Health Insurance Portability and Accountability Act of 1996 (26 U.S.C. 9801(c)(1)).
(26) That the contract provides, upon request of the subscriber, coverage for a child of the subscriber until the date the child becomes twenty-four (24) years of age.

(b) For purposes of subsection (a), an evidence of coverage which is filed with a contract may be considered part of the contract.

SECTION 40. [EFFECTIVE JULY 1, 2007] **The state personnel department shall implement the requirements of IC 5-10-8-6.7 and IC 5-10-8-6.8, both as added by this act, not later than July 1, 2008.**

SECTION 41. [EFFECTIVE JULY 1, 2007] **IC 6-3.1-31, as added by this act, applies to taxable years beginning after December 31, 2007.**

SECTION 42. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.**

(b) The office shall apply to the United States Department of Health and Human Services for any amendment to the state Medicaid plan or demonstration waiver that is needed to do the following:

(1) Implement IC 12-17.6-3-2 and IC 12-15-2-13, both as amended by this act.

(2) Provide for presumptive eligibility for a pregnant woman

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described in IC 12-15-2-13, as amended by this act.

(c) The office may not implement the amendment or waiver until the office files an affidavit with the governor attesting that the amendment or waiver applied for under this SECTION is in effect. The office shall file the affidavit under this subsection not more than five (5) days after the office is notified that the amendment or waiver is approved.

(d) If the office receives approval for the amendment or waiver under this SECTION from the United States Department of Health and Human Services and the governor receives the affidavit filed under subsection (c), the office shall implement the amendment or waiver not more than sixty (60) days after the governor receives the affidavit.

(e) The office may adopt rules under IC 4-22-2 to implement this SECTION.

SECTION 43. [EFFECTIVE JULY 1, 2007] **(a) IC 27-8-5-2, as amended by this act, and IC 27-8-5-28, as added by this act, apply to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2007.**

(b) IC 27-13-7-3, as amended by this act, applies to a health maintenance organization contract that is entered into, delivered, amended, or renewed after June 30, 2007.

SECTION 44. [EFFECTIVE JULY 1, 2007] **(a) There is appropriated to the office of Medicaid policy and planning from the healthier Indiana insurance trust fund (as established by IC 12-15-44-14, as added by this act) fifteen million dollars ($15,000,000) for the period beginning July 1, 2007, and ending June 30, 2009, to provide funding to increase reimbursement rates under the state Medicaid program (IC 12-15) and the children's health insurance program (IC 12-17.6) for services provided by primary care physicians who are licensed under IC 25-22.5.**

(b) There is appropriated to the rural health care pilot program support fund (as established by IC 16-45-4-3, as added by this act) from the healthier Indiana insurance trust fund (as established by IC 12-15-44-14, as added by this act) two hundred fifty thousand dollars ($250,000) for the period beginning July 1, 2007, and ending June 30, 2009, to provide funding for the purpose of making grants to Indiana health care providers who participate in the rural health care pilot program.

(c) This SECTION expires July 1, 2009.

SECTION 45. [EFFECTIVE JULY 1, 2007] **(a) The definitions under IC 12-15-44 apply to this SECTION.**

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(b) As used in this SECTION, "task force" refers to the healthier Indiana insurance program task force established by subsection (c).

(c) The healthier Indiana insurance program task force is established to:

(1) study, monitor, provide guidance, and make recommendations to the state concerning the healthier Indiana insurance program;

(2) develop methods to increase availability of affordable coverage for health care services for all Indiana residents;

(3) develop an education and orientation program for individuals participating in the program; and

(4) make recommendations to the legislative council.

(d) The task force:

(1) shall operate under the policies governing study committees adopted by the legislative council; and

(2) may request funding from the legislative council to hire consultants.

(e) The affirmative votes of a majority of the voting members appointed to the task force are required for the task force to take action on any measure, including final reports.

(f) The office shall provide administrative assistance to and staff the task force.

(g) The task force consists of the following voting members:

(1) Eleven (11) members appointed by the speaker of the house of representatives, three (3) of whom are appointed based on the recommendation of the minority leader of the house of representatives and none of whom are legislators.

(2) Eleven (11) members appointed by the president pro tempore of the senate, three (3) of whom are appointed based on the recommendation of the minority leader of the senate and none of whom are legislators.

(h) In making appointments under subsection (g), the speaker of the house of representatives shall appoint members representing the interests listed in subdivisions (1) through (5) and the president pro tempore of the senate shall each appoint members representing the interests listed in subdivisions (6) through (11) as follows:

(1) Hospitals.

(2) Insurance companies.

(3) Primary care providers.

(4) Health professionals who are not primary care providers.

(5) Minority health concern experts.

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(6) Business.
(7) Organized labor.
(8) Consumers.
(9) Children's health issues.
(10) Adult health issues.
(11) Health marketing and public relations.

(i) The chairman of the legislative council shall appoint the chairperson of the task force.

(j) The task force shall report findings and make recommendations in a final report to the legislative council in an electronic format under IC 5-14-6 before November 1, 2008.

(k) The task force expires November 1, 2008, unless the legislative council extends the work of the task force until November 1, 2009. If the legislative council extends the work of the task force until November 1, 2009, the task force shall submit additional findings and recommendations in a final report before November 1, 2009.

(l) The task force members are not eligible for per diem reimbursement or reimbursement for expenses incurred for travel to and from task force meetings.

(m) This SECTION expires January 1, 2010.

SECTION 46. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.**

(b) The office shall apply to the United States Department of Health and Human Services for approval of a Section 1115 demonstration waiver to develop and implement a health insurance program to cover individuals who meet the following requirements:

(1) The individual is at least eighteen (18) years of age and less than sixty-five (65) years of age.
(2) The individual is a United States citizen and has been a resident of Indiana for at least twelve (12) months.
(3) The individual has an annual household income of not more than two hundred percent (200%) of the federal income poverty level.
(4) The individual is not eligible for health insurance coverage through the individual's employer.
(5) The individual has been without health insurance coverage for at least six (6) months or is without health insurance coverage because of a change in employment.

(c) The office shall include in the waiver application a request

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to fund the program in part by using:

(1) costs not otherwise matchable dollars; and

(2) hospital care for the indigent dollars, upper payment limit dollars, or disproportionate share hospital dollars.

(d) The office may not implement the waiver until the office:

(1) files an affidavit with the governor attesting that the federal waiver applied for under this SECTION is in effect; and

(2) has sufficient funding for the program.

The office shall file the affidavit under this subsection not later than five (5) days after the office is notified that the waiver is approved.

(e) The office may adopt rules under IC 4-22-2 necessary to implement this SECTION.

(f) This SECTION expires December 31, 2013.

SECTION 47. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.**

(b) The office shall apply to the United States Department of Health and Human Services for approval of an amendment to the state's Medicaid plan that is necessary to do the following:

(1) Amend the state's upper payment limit program.

(2) Make changes to the state's disproportionate share hospital program.

(c) The office may not implement an approved amendment to the state plan until the office files an affidavit with the governor attesting that the state plan amendment applied for under subsection (b)(1) or (b)(2) of this SECTION is in effect. The office shall file the affidavit under this subsection not later than five (5) days after the office is notified that the state plan amendment is approved.

(d) The office may adopt rules under IC 4-22-2 necessary to implement this SECTION.

(e) This SECTION expires December 31, 2013.

SECTION 48. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "commission" refers to the health finance commission established by IC 2-5-23-3.**

(b) As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.

(c) The office shall report to the commission during the 2007 interim, updating the commission on the status of the development and implementation of the healthier Indiana insurance program

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established by IC 12-15-44-4, as added by this act.

(d) This SECTION expires December 31, 2008.

SECTION 49. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "small employer" means any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on at least fifty percent (50%) of the working days of the employer during the preceding calendar year, employed at least two (2) but not more than fifty (50) eligible employees, the majority of whom work in Indiana. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.**

(b) The commissioner of the department of insurance and the office of the secretary of family and social services shall, not later than January 1, 2008, implement a program to allow two (2) or more small employers to join together to purchase health insurance, as described in IC 27-8-5-16(8), as amended by this act.

(c) The commissioner shall adopt rules under IC 4-22-2 necessary to implement this SECTION.

SECTION 50. **An emergency is declared for this act.**

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SENATE MOTION

Madam President: I move that Senator Simpson be added as second author of Senate Bill 503.

MILLER

SENATE MOTION

Madam President: I move that Senator Errington be added as coauthor of Senate Bill 503.

MILLER

SENATE MOTION

Madam President: I move that Senator Sipes be added as coauthor of Senate Bill 503.

MILLER

SENATE MOTION

Madam President: I move that Senator Becker be added as third author and Senator Rogers be added as coauthor of Senate Bill 503.

MILLER

COMMITTEE REPORT

Madam President: The Senate Committee on Health and Provider Services, to which was referred Senate Bill No. 503, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 6, line 36, strike "shortfall" and insert "**supplemental payment**".

Page 6, line 40, strike "Payment for a state fiscal year ending after June 30,".

Page 6, strike line 41.

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Page 6, line 42, strike "year's end.".
Page 7, line 9, strike "STEP SEVEN of".
Page 7, strike lines 10 through 12.
Page 7, line 13, strike "(b)." and insert "**this section.**".
Page 7, line 14, after "section" insert ".".
Page 7, line 14, strike "and as otherwise provided under".
Page 7, line 15, delete "IC 12-15-20-2(6).".
Page 7, line 17, strike "subsection (d)" and insert "**this section**".
Page 7, line 18, strike "STEP SEVEN of".
Page 7, line 22, strike "STEP".
Page 7, line 23, strike "SEVEN of".
Page 7, line 26, strike "STEP SEVEN of".
Page 7, line 32, strike "shortfall" and insert "**supplemental payment**".
Page 8, line 5, strike "shortfall" and insert "**supplemental payment**".
Page 9, line 16, strike "shortfall" and insert "**supplemental payment**".
Page 9, line 18, strike "Subject to subsection (e), the reimbursement for a state fiscal".
Page 9, strike line 19.
Page 9, line 20, strike "following the end of the state fiscal year.".
Page 9, line 22, strike "under subsection (d)." and insert "**by the hospital or on behalf of the hospital.**".
Page 9, line 29, strike "STEP SEVEN of".
Page 9, line 30, strike "In determining the percentage, the office shall apply the".
Page 9, strike lines 31 through 32.
Page 9, line 33, strike "(b).".
Page 9, line 34, after "section" insert "."
Page 9, line 34, strike "and as otherwise provided under".
Page 9, line 35, delete "IC 12-15-20-2(6).".
Page 9, line 37, strike "subsection (d)" and insert "**this section**".
Page 9, line 38, strike "STEP SEVEN of".
Page 9, line 42, strike "STEP".
Page 10, line 1, strike "SEVEN of".
Page 10, line 4, strike "STEP SEVEN of".
Page 10, line 10, strike "shortfall" and insert "**supplemental payment**".
Page 10, line 25, strike "shortfall" and insert "**supplemental payment**".
Page 11, line 1, after "2003," insert "**and before July 1, 2005,**".

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Page 11, line 27, reset in roman "IC 12-15-20-2(8)(D)".

Page 11, line 27, delete "**IC 12-15-20-2(6)(D)**".

Page 12, strike lines 18 through 21.

Page 12, between lines 21 and 22, begin a new paragraph and insert:

"**(c) For state fiscal years ending after July 1, 2005, in addition to reimbursement received under section 1 of this chapter, a hospital eligible under this section is entitled to reimbursement in an amount calculated as follows:**

STEP ONE: The office shall identify the total inpatient hospital services and the total outpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by a hospital described in subsection (a).

STEP TWO: For the total inpatient hospital services and the total outpatient hospital services identified under STEP ONE, the office shall calculate the total payments made under this article and under the state Medicaid plan to a hospital described in subsection (a), excluding payments made under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the total amount that would have been paid by the office for the inpatient hospital services and the outpatient hospital services identified in STEP ONE under Medicare payment principles.

STEP FOUR: Subtract the amount calculated under STEP TWO from the amount calculated under STEP THREE.

STEP FIVE: Distribute an amount equal to the amount calculated under STEP FOUR to the eligible hospitals described in subsection (a) as follows:

(A) Subject to the availability of funds under IC 12-15-20-2(7) to serve as the non-federal share of the payments, the amount calculated under STEP FOUR for a state fiscal year shall be paid to all hospitals described in subsection (a). The payments shall be made on a pro rata basis based on the hospitals' Medicaid inpatient days or, if the federal Centers for Medicare and Medicaid Services do not approve that methodology, another payment methodology approved by the federal Centers for Medicare and Medicaid Services. For purposes of this clause, a hospital's Medicaid inpatient days are the hospital's in-state Medicaid paid claims and Medicaid managed care days for the state fiscal year referenced in

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STEP ONE, as determined by the office.

(B) Subject to IC 12-15-20.7, if the entirety of the amount calculated under STEP FOUR is not distributed following the payments made under clause (A), the remaining amount shall be paid to hospitals described in subsection (a) that are eligible under this clause. A hospital is eligible for a payment under this clause only if the hospital:

(i) has less than seventy thousand (70,000) Medicaid inpatient days annually;

(ii) was eligible for disproportionate share hospital payments under IC 12-15-19-2.1 for the state fiscal year ending June 30, 1998, or the hospital met the office's Medicaid disproportionate share payment criteria for payment under IC 12-15-19-2.1 based upon state fiscal year 1998 data and received a Medicaid disproportionate share payment for the state fiscal year ending June 30, 2001; and

(iii) received a Medicaid disproportionate share payment under IC 12-15-19-2.1 for state fiscal years 2001, 2002, 2003, and 2004.

The amount of a hospital's payment under this clause is subject to the extent that Medicaid indigent care trust funds are available or, if none are available, the non-federal share of the hospital's payment is provided by or on behalf of the hospital. The payment to each hospital shall equal the hospital's hospital specific limit provided under 42 U.S.C. 1396r-4 when the payments are combined with any other Medicaid payments made to the hospital. For state fiscal years ending before July 1, 2008, the total payments made under this clause may not exceed a total amount of sixty-eight million dollars ($68,000,000). For a state fiscal year ending after June 30, 2008, the total payments made under this clause may not exceed a total amount of sixty-eight million dollars ($68,000,000) plus the annual percentage growth in the state's aggregate Medicaid upper payment limit, as calculated by the office.

(C) Subject to IC 12-15-20.7, if the entirety of the amount calculated under STEP FOUR is not distributed following the payments made under clauses (A) and (B), the remaining amount may be paid to hospitals described in subsection (a) that are eligible under this clause. A hospital is eligible for a payment under this clause if the hospital:

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(i) has less than seventy thousand (70,000) Medicaid inpatient days annually;

(ii) has received or is eligible to receive Medicaid disproportionate share payments under IC 12-15-19-2.1 for state fiscal years 2002, 2003, 2004, and for each state fiscal year after 2004; and

(iii) provides, or has provided on the hospital's behalf, the non-federal share of the hospital's payment.

A payment to a hospital under this clause is subject to the availability of non-federal dollars. The payment to each hospital shall not exceed ninety percent (90%) of the hospital's Medicaid shortfall. As used in this clause, Medicaid shortfall is the amount of the hospital's Medicaid costs less the hospital's Medicaid reimbursement and any payments received by the hospital under IC 12-15-15-9 and IC 12-15-15-9.5. For state fiscal years ending before July 1, 2008, the total payments made under this clause may not exceed a total amount of twenty-three million five hundred thousand dollars ($23,500,000). For a state fiscal year ending after June 30, 2008, the total payments made under this clause may not exceed a total amount of twenty-three million five hundred thousand dollars ($23,500,000) plus the annual percentage growth in the state's aggregate Medicaid upper payment limit, as determined by the office.

(D) Subject to IC 12-15-20.7, if the entirety of the amount calculated under STEP FOUR is not distributed following the payments made under clauses (A) through (C), the remaining amount shall be paid to hospitals described in subsection (a) that are eligible under this clause. A hospital is eligible for payment under this clause if the hospital provides, or has provided on the hospital's behalf, the non-federal share of the hospital's payment.

(E) As used in clauses (A) through (D), a hospital's Medicaid inpatient days are based on the hospital's Medicaid paid claims and Medicaid managed care days for the current state fiscal year, as determined by the office.".

Page 12, line 24, delete "." and insert "**or subsection (c).**".

Page 12, line 25, after "(b)" insert "**or subsection (c)**".

Page 12, line 28, after "(b)" insert "**or subsection (c)**".

Page 12, between lines 32 and 33, begin a new paragraph and insert:

"SECTION 8. IC 12-15-15-9 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 9. (a) For purposes of

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this section and IC 12-16-7.5-4.5, a payable claim is attributed to a county if the payable claim is submitted to the division by a hospital licensed under IC 16-21-2 for payment under IC 12-16-7.5 for care provided by the hospital to an individual who qualifies for the hospital care for the indigent program under IC 12-16-3.5-1 or IC 12-16-3.5-2 and:

(1) who is a resident of the county;

(2) who is not a resident of the county and for whom the onset of the medical condition that necessitated the care occurred in the county; or

(3) whose residence cannot be determined by the division and for whom the onset of the medical condition that necessitated the care occurred in the county.

(b) For each state fiscal year ending after June 30, 2003, **and before July 1, 2006,** a hospital licensed under IC 16-21-2 that submits to the division during the state fiscal year a payable claim under IC 12-16-7.5 is entitled to a payment under ~~this section.~~ **subsection (c).**

(c) Except as provided in section 9.8 of this chapter and subject to section 9.6 of this chapter, for a state fiscal year, the office shall pay to a hospital referred to in subsection (b) an amount equal to the amount, based on information obtained from the division and the calculations and allocations made under IC 12-16-7.5-4.5, that the office determines for the hospital under STEP SIX of the following STEPS:

STEP ONE: Identify:

(A) each hospital that submitted to the division one (1) or more payable claims under IC 12-16-7.5 during the state fiscal year; and

(B) the county to which each payable claim is attributed.

STEP TWO: For each county identified in STEP ONE, identify:

(A) each hospital that submitted to the division one (1) or more payable claims under IC 12-16-7.5 attributed to the county during the state fiscal year; and

(B) the total amount of all hospital payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year.

STEP THREE: For each county identified in STEP ONE, identify the amount of county funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).

STEP FOUR: For each hospital identified in STEP ONE, with respect to each county identified in STEP ONE, calculate the hospital's percentage share of the county's funds transferred to the Medicaid indigent care trust fund under STEP FOUR of

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IC 12-16-7.5-4.5(b). Each hospital's percentage share is based on the total amount of the hospital's payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year, calculated as a percentage of the total amount of all hospital payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year.

STEP FIVE: Subject to subsection (j), for each hospital identified in STEP ONE, with respect to each county identified in STEP ONE, multiply the hospital's percentage share calculated under STEP FOUR by the amount of the county's funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).

STEP SIX: Determine the sum of all amounts calculated under STEP FIVE for each hospital identified in STEP ONE with respect to each county identified in STEP ONE.

(d) For state fiscal years beginning after June 30, 2006, a hospital that received a payment determined under STEP SIX of subsection (c) for the state fiscal year ending June 30, 2006, shall be paid in an amount equal to the amount determined for the hospital under STEP SIX of subsection (c) for the state fiscal year ending June 30, 2006.

~~(d)~~ **(e)** A hospital's payment under subsection (c) **or (d)** is in the form of a Medicaid ~~add-on~~ **supplemental** payment. The amount of a hospital's ~~add-on~~ **Medicaid supplemental** payment is subject to the availability of funding for the non-federal share of the payment under subsection ~~(c).~~ **(f).** The office shall make the payments under ~~subsection~~ **subsections** (c) **and (d)** before December 15 that next succeeds the end of the state fiscal year.

~~(e)~~ **(f)** The non-federal share of a payment to a hospital under subsection (c) **or (d)** is funded from the funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) of each county to which a payable claim under IC 12-16-7.5 submitted to the division during the state fiscal year by the hospital is attributed.

~~(f)~~ **(g)** The amount of a county's transferred funds available to be used to fund the non-federal share of a payment to a hospital under subsection (c) **or (d)** is an amount that bears the same proportion to the total amount of funds of the county transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) that the total amount of the hospital's payable claims under IC 12-16-7.5 attributed to the county submitted to the division during the state fiscal year bears to the total amount of all hospital payable claims under IC 12-16-7.5

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attributed to the county submitted to the division during the state fiscal year.

~~(g)~~ **(h)** Any county's funds identified in subsection ~~(f)~~ **(g)** that remain after the non-federal share of a hospital's payment has been funded are available to serve as the non-federal share of a payment to a hospital under section 9.5 of this chapter.

~~(h)~~ **(i)** For purposes of this section, "payable claim" has the meaning set forth in IC 12-16-7.5-2.5(b)(1).

~~(i)~~ **(j)** For purposes of this section:

(1) the amount of a payable claim is an amount equal to the amount the hospital would have received under the state's fee-for-service Medicaid reimbursement principles for the hospital care for which the payable claim is submitted under IC 12-16-7.5 if the individual receiving the hospital care had been a Medicaid enrollee; and

(2) a payable hospital claim under IC 12-16-7.5 includes a payable claim under IC 12-16-7.5 for the hospital's care submitted by an individual or entity other than the hospital, to the extent permitted under the hospital care for the indigent program.

~~(j)~~ **(k)** The amount calculated under STEP FIVE of subsection (c) for a hospital with respect to a county may not exceed the total amount of the hospital's payable claims attributed to the county during the state fiscal year.".

Page 13, line 6, after "2003," insert "**but before July 1, 2006,**".

Page 13, line 14, strike "this section." and insert "**subsection (c).**".

Page 14, between lines 15 and 16, begin a new paragraph and insert:

"**(d) For state fiscal years beginning after June 30, 2006, a hospital that received a payment determined under STEP EIGHT of subsection (c) for the state fiscal year ending June 30, 2006, will be paid an amount equal to the amount determined for the hospital under STEP EIGHT of subsection (c) for the state fiscal year ending June 30, 2006.**".

Page 14, line 16, strike "(d)" and insert "**(e)**".

Page 14, line 16, after "(c)" insert "**or (d)**".

Page 14, line 17, strike "add-on" and insert "**supplemental**".

Page 14, line 19, strike "(e)." and insert "**(f).**".

Page 14, line 20, after "(c)" insert "**or (d)**".

Page 14, line 22, strike "(e)" and insert "**(f)**".

Page 14, line 23, after "(c)" insert "**or (d)**".

Page 14, line 25, strike "To the extent possible,".

Page 14, strike lines 26 through 41.

Page 14, line 42, strike "(f)" and insert "**(g)**".

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Page 14, line 42, strike "(g)," and insert "**(h),**".

Page 15, line 3, strike "(g)" and insert "**(h)**".

Page 15, line 12, strike "(h)" and insert "**(i)**".

Page 15, line 15, delete "IC 12-15-20-2(6)(D)." and insert "**IC 12-15-20-2(8).**".

Page 15, line 16, strike "(i)" and insert "**(j)**".

Page 16, line 21, after "under" insert "**IC 12-15-16, IC 12-15-17, or IC 12-15-19 of**".

Page 16, line 31, strike "or".

Page 16, line 33, delete "." and insert "; **or**

(3) other permissible sources of non-federal share dollars.".

Page 16, between lines 40 and 41, begin a new paragraph and insert:

"SECTION 12. IC 12-15-19-2.1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2.1. (a) For each state fiscal year ending on or after June 30, 2000, the office shall develop a disproportionate share payment methodology that ensures that each hospital qualifying for disproportionate share payments under IC 12-15-16-1(a) timely receives total disproportionate share payments that do not exceed the hospital's hospital specific limit provided under 42 U.S.C. 1396r-4(g). The payment methodology as developed by the office must:

(1) maximize disproportionate share hospital payments to qualifying hospitals to the extent practicable;

(2) take into account the situation of those qualifying hospitals that have historically qualified for Medicaid disproportionate share payments; and

(3) ensure that payments net of intergovernmental transfers made by or on behalf of qualifying hospitals are equitable.

(b) Total disproportionate share payments to a hospital under this chapter shall not exceed the hospital specific limit provided under 42 U.S.C. 1396r-4(g). The hospital specific limit for a state fiscal year shall be determined by the office taking into account data provided by each hospital that is considered reliable by the office based on a system of periodic audits, the use of trending factors, and an appropriate base year determined by the office. The office may require independent certification of data provided by a hospital to determine the hospital's hospital specific limit.

(c) The office shall include a provision in each amendment to the state plan regarding Medicaid disproportionate share payments that the office submits to the federal Centers for Medicare and Medicaid Services that, as provided in 42 CFR 447.297(d)(3), allows the state to make additional disproportionate share expenditures after the end of

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each federal fiscal year that relate back to a prior federal fiscal year. However, the total disproportionate share payments to:

(1) each individual hospital; and

(2) all qualifying hospitals in the aggregate;

may not exceed the limits provided by federal law and regulation.

(d) ~~The office shall, in each state fiscal year, provide sufficient funds for acute care hospitals licensed under IC 16-21 that qualify for disproportionate share payments under IC 12-15-16-1(a). Funds provided under this subsection:~~

~~(1) do not include funds transferred by other governmental units to the Medicaid indigent care trust fund; and~~

~~(2) must be in an amount equal to the amount that results from the following calculation:~~

~~STEP ONE: Multiply twenty-six million dollars ($26,000,000) by the federal medical assistance percentage.~~

~~STEP TWO: Subtract the amount determined under STEP ONE from twenty-six million dollars ($26,000,000).~~

A hospital that receives a payment under clause (B) of STEP FIVE of IC 12-15-15-1.5(c) is not eligible for a disproportionate share payment under this section.

SECTION 13. IC 12-15-19-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 6. (a) The office is not required to make disproportionate share payments under this chapter from the Medicaid indigent care trust fund established by IC 12-15-20-1 until the fund has received sufficient deposits to permit the office to make the state's share of the required disproportionate share payments.

(b) If:

(1) sufficient deposits have not been received; **or**

(2) the statewide Medicaid disproportionate share allocation is not sufficient to provide federal financial participation for the entirety of all eligible disproportionate share hospitals' specific limits;

the office ~~shall~~ **may** reduce disproportionate share payments **under IC 12-15-19-2.1** to ~~all~~ eligible institutions by ~~the same~~ **a** percentage **as long as, for each state fiscal year beginning after June 30, 2006, a hospital established under IC 16-22-8 receives at least sixty percent (60%) of the hospital's remaining hospital specific limit for each state fiscal year.** The percentage reduction shall be sufficient to ensure that payments do not exceed the **statewide Medicaid disproportionate share allocation or the** amounts that can be financed with the ~~state~~ **non-federal** share that is in the fund,

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intergovernmental transfers, certifications of public expenditures, or other permissible sources of non-federal match.".

Page 17, line 4, delete "," and insert "**and the total amount available for municipal disproportionate share payments in subsection (d),**".

Page 17, line 12, strike "the amount of".

Page 17, strike line 13.

Page 17, line 14, strike "IC 12-15-16-6 or sections 1 or 2.1 of this chapter." and insert "**all Medicaid payments, including Medicaid supplemental payments and other Medicaid disproportionate share payments received by the provider.**".

Page 17, line 22, strike "disproportionate share" and insert "**Medicaid supplemental**".

Page 17, line 23, strike "equals" and insert "**do not exceed**".

Page 18, line 8, delete "is forty million dollars ($40,000,000)." and insert "**may not exceed thirty-five million dollars ($35,000,000).**".

Page 18, between lines 8 and 9, begin a new paragraph and insert:

"SECTION 14. IC 12-15-19-10, AS AMENDED BY P.L.2-2005, SECTION 49, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 10. For state fiscal years beginning after June 30, 2000, **and ending June 30, 2003**, the state shall pay providers as follows:

(1) The state shall make municipal disproportionate share provider payments to providers qualifying under IC 12-15-16-1(b) until the state exceeds the state disproportionate share allocation (as defined in 42 U.S.C. 1396r-4(f)(2)).

(2) After the state makes all payments under subdivision (1), if the state fails to exceed the state disproportionate share allocation (as defined in 42 U.S.C. 1396r-4(f)(2)), the state shall make disproportionate share provider payments to providers qualifying under IC 12-15-16-1(a).

(3) After the state makes all payments under subdivision (2), if the state fails to exceed the state disproportionate share allocation (as defined in 42 U.S.C. 1396r-4(f)(2)), or the state limit on disproportionate share expenditures for institutions for mental diseases (as defined in 42 U.S.C. 1396r-4(h)), the state shall make community mental health center disproportionate share provider payments to providers qualifying under IC 12-15-16-1(c).".

Page 18, reset in roman lines 22 and 23.

Page 18, line 24, reset in roman "(7)".

Page 18, line 24, delete "(5)".

Page 18, line 25, after "(D)" insert ",".

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Page 18, line 25, strike "and".

Page 18, line 25, delete "." and insert ", **and (8)(G).**".

Page 18, line 26, reset in roman "(8)".

Page 18, line 26, delete "(6)".

Page 19, line 23, after "2003," insert "**but before July 1, 2005,**".

Page 19, line 36, reset in roman "the non-federal share of payments to hospitals under".

Page 19, reset in roman line 37.

Page 19, line 38, reset in roman "under IC 12-15-15-9.5,".

Page 19, reset in roman lines 41 through 42.

Page 20, reset in roman lines 1 through 9.

Page 20, line 10, reset in roman "(F)".

Page 20, line 10, delete "(E)".

Page 20, line 11, delete "2006," and insert "**2005,**".

Page 20, line 29, delete "(F)" and insert "**(G)**".

Page 20, line 29, delete "2006," and insert "**2005,**".

Page 20, line 30, delete "entirety of the" and insert "**total amount of**".

Page 20, line 31, delete "for" and insert "**as follows:**

(1) Thirty million dollars ($30,000,000) shall be transferred to the office for the Medicaid budget.

(2) An amount not to exceed eleven million six hundred fifty thousand dollars ($11,650,000) to fund the non-federal share of payments to hospitals under IC 12-15-15-9 and IC 12-15-15-9.5.

(3) An amount not to exceed eight million nine hundred seventy-five thousand dollars ($8,975,000) to fund the non-federal share of payments to hospitals made under clause (A) of STEP FIVE of IC 12-15-15-1.5(c).

(4) To fund the non-federal share of payments to hospitals made under clause (B) of STEP FIVE of IC 12-15-15-1.5(c).

(5) To fund the non-federal share of payments to hospitals made under clause (C) of STEP FIVE of IC 12-15-15-1.5(c).

(6) To fund the non-federal share of disproportionate share payments to hospitals under IC 12-15-19-2.1.

(7) If additional funds are available after making payments under subdivisions (1) through (6), to fund other Medicaid supplemental payments for hospitals approved by the office and included in the state Medicaid plan.".

Page 20, delete lines 32 through 34.

Page 20, line 36, after "Sec. 2." insert "**(a)**".

Page 20, line 37, delete "year," and insert "year **ending before July**

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1, 2005,".

Page 20, reset in roman line 39.

Page 20, line 40, reset in roman "(2) Second,".

Page 20, line 40, delete "(1) First,".

Page 20, line 42, reset in roman "(3) Third,".

Page 20, line 42, delete "(2) Second,".

Page 21, reset in roman line 3.

Page 21, line 4, reset in roman "(5) Fifth,".

Page 21, line 4, delete "(3) Third,".

Page 21, line 6, reset in roman "(6) Sixth,".

Page 21, line 6, delete "(4) Fourth,".

Page 21, reset in roman lines 8 and 9.

Page 21, between lines 9 and 10, begin a new paragraph and insert:

"**(b) For each state fiscal year ending after June 30, 2005, subject to section 3 of this chapter, the office shall make the payments identified in this section in the following order:**

(1) First, the payment under IC 12-15-20-2(8)(G).

(2) Second, payments under IC 12-15-15-1.1 and IC 12-15-15-1.3.

(3) Third, payments under IC 12-15-19-8.

(4) Fourth, payments under IC 12-15-15-9 and IC 12-15-15-9.5.

(5) Fifth, payments under clause (A) of STEP FIVE of IC 12-15-15-1.5(c).

(6) Sixth, payments under clause (B) of STEP FIVE of IC 12-15-15-1.5(c).

(7) Seventh, payments under clause (C) of STEP FIVE of IC 12-15-15-1.5(c).

(8) Eighth, payments under clause (D) of STEP FIVE of IC 12-15-15-1.5(c).

(9) Ninth, payments under IC 12-15-19-2.1 for disproportionate share hospitals.".

Page 21, line 32, after "program." insert "**The department of insurance and the office of the secretary shall provide oversight on the marketing practices of the program.**".

Page 21, between lines 40 and 41, begin a new paragraph and insert:

"**(d) The program must include the following in a manner and to the extent determined by the office:**

(1) Mental health care services.

(2) Inpatient hospital services.

(3) Prescription drug coverage.

(4) Emergency room services.

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(5) Physician office services.
(6) Diagnostic services.
(7) Outpatient services, including therapy services.
(8) Disease management.
(9) Home health services.
(10) Urgent care center services.".

Page 24, line 25, after "Sec. 12." insert "**(a)**".

Page 24, between lines 39 and 40, begin a new paragraph and insert:

"**(b) An insurer or a health maintenance organization that has contracted with the office to provide health insurance under the program shall also offer to provide the same health insurance to the following:**

(1) An individual who has an annual household income that is:
(A) not more than two hundred percent (200%) of the federal income poverty level but the individual is not eligible for the program because of the individual's income or because a slot is not available for the individual; or
(B) more than two hundred percent (200%) of the federal income poverty level.

(2) The employees of an employer if:
(A) the employees have an annual household income that is more than two hundred percent (200%) of the federal income poverty level; and
(B) the employer:
(i) has not offered employees health care insurance in the previous twelve (12) months; and
(ii) pays at least fifty percent (50%) of the premium for the employer's employees.

The state does not provide funding for coverage provided under this subsection.".

Page 25, line 19, delete "The" and insert "**Either:**
(A) the individual is no longer eligible for the program because the individual's annual household income exceeds the amounts set forth in section 5(a)(3) of this chapter; or
(B) the".

Page 27, delete lines 10 through 42.

Delete page 28.

Page 29, delete lines 1 through 33.

Page 30, line 21, delete "Except as provided in subsection (c), before" and insert "Before".

Page 31, line 1, reset in roman "IC 12-15-20-2(8)(D)".

Page 31, line 1, delete "IC 12-15-20-2(6)(D)" and insert "**or**

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IC 12-15-20-2(8)(G)".

Page 31, delete lines 8 through 24.

Page 31, line 25, reset in roman "(c)".

Page 31, line 25, delete "(d)".

Page 31, line 30, strike "(a) For purposes of this section,".

Page 31, strike line 31.

Page 31, line 32, strike "(b)" and insert "**(a)**".

Page 31, line 39, strike "(c)" and insert "**(b)**".

Page 31, line 39, reset in roman "first".

Page 31, line 39, after "payable" delete ",".

Page 31, line 39, reset in roman "in 2004,".

Page 31, line 40, after "2008," insert "**and each year thereafter,**".

Page 31, line 41, strike "product of:" and insert "**hospital care for the indigent program property tax levy for taxes first due and payable in the preceding calendar year multiplied by the statewide average assessed value growth quotient, using all the county assessed value growth quotients determined under IC 6-1.1-18.5-2 for the year in which the tax levy under this subsection will be first due and payable.**".

Page 31, strike line 42.

Page 32, strike lines 1 through 15.

Page 33, between lines 9 and 10, begin a new paragraph and insert:

"SECTION 21. IC 27-8-5-16 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 16. Except as provided in sections 17 and 24 of this chapter, no policy of group accident and sickness insurance may be delivered or issued for delivery to a group that has a legal situs in Indiana unless it conforms to one (1) of the following descriptions:

(1) A policy issued to an employer or to the trustees of a fund established by an employer (which employer or trustees must be deemed the policyholder) to insure employees of the employer for the benefit of persons other than the employer, subject to the following requirements:

(A) The employees eligible for insurance under the policy must be all of the employees of the employer, or all of any class or classes of employees. The policy may provide that the term "employees" includes the employees of one (1) or more subsidiary corporations and the employees, individual proprietors, members, and partners of one (1) or more affiliated corporations, proprietorships, limited liability companies, or partnerships if the business of the employer and of the affiliated corporations, proprietorships, limited liability

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companies, or partnerships is under common control. The policy may provide that the term "employees" includes retired employees, former employees, and directors of a corporate employer. A policy issued to insure the employees of a public body may provide that the term "employees" includes elected or appointed officials.

(B) The premium for the policy must be paid either from the employer's funds, from funds contributed by the insured employees, or from both sources of funds. Except as provided in clause (C), a policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, except those who reject the coverage in writing.

(C) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(2) A policy issued to a creditor or its parent holding company or to a trustee or trustees or agent designated by two (2) or more creditors (which creditor, holding company, affiliate, trustee, trustees, or agent must be deemed the policyholder) to insure debtors of the creditor, or creditors, subject to the following requirements:

(A) The debtors eligible for insurance under the policy must be all of the debtors of the creditor or creditors, or all of any class or classes of debtors. The policy may provide that the term "debtors" includes:

(i) borrowers of money or purchasers or lessees of goods, services, or property for which payment is arranged through a credit transaction;

(ii) the debtors of one (1) or more subsidiary corporations; and

(iii) the debtors of one (1) or more affiliated corporations, proprietorships, limited liability companies, or partnerships if the business of the policyholder and of the affiliated corporations, proprietorships, limited liability companies, or partnerships is under common control.

(B) The premium for the policy must be paid either from the creditor's funds, from charges collected from the insured debtors, or from both sources of funds. Except as provided in clause (C), a policy on which no part of the premium is to be derived from the funds contributed by insured debtors specifically for their insurance must insure all eligible debtors.

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(C) An insurer may exclude any debtors as to whom evidence of individual insurability is not satisfactory to the insurer.

(D) The amount of the insurance payable with respect to any indebtedness may not exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor. The insurer may exclude any payments that are delinquent on the date the debtor becomes disabled as defined in the policy.

(E) The insurance may be payable to the creditor or any successor to the right, title, and interest of the creditor. Each payment under this clause must reduce or extinguish the unpaid indebtedness of the debtor to the extent of the payment, and any excess of the insurance must be payable to the insured or the estate of the insured.

(F) Notwithstanding clauses (A) through (E), insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment on a nondecreasing or level term plan, and insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan.

(3) A policy issued to a labor union or similar employee organization (which must be deemed to be the policyholder) to insure members of the union or organization for the benefit of persons other than the union or organization or any of its officials, representatives, or agents, subject to the following requirements:

(A) The members eligible for insurance under the policy must be all of the members of the union or organization, or all of any class or classes of members.

(B) The premium for the policy must be paid either from funds of the union or organization, from funds contributed by the insured members specifically for their insurance, or from both sources of funds. Except as provided in clause (C), a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, except those who reject the coverage in writing.

(C) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(4) A policy issued to a trust or to one (1) or more trustees of a fund established or adopted by two (2) or more employers, or by one (1) or more labor unions or similar employee organizations,

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or by one (1) or more employers and one (1) or more labor unions or similar employee organizations (which trust or trustees must be deemed the policyholder) to insure employees of the employers or members of the unions or organizations for the benefit of persons other than the employers or the unions or organizations, subject to the following requirements:

(A) The persons eligible for insurance must be all of the employees of the employers or all of the members of the unions or organizations, or all of any class or classes of employees or members. The policy may provide that the term "employees" includes the employees of one (1) or more subsidiary corporations and the employees, individual proprietors, and partners of one (1) or more affiliated corporations, proprietorships, limited liability companies, or partnerships if the business of the employer and of the affiliated corporations, proprietorships, limited liability companies, or partnerships is under common control. The policy may provide that the term "employees" includes retired employees, former employees, and directors of a corporate employer. The policy may provide that the term "employees" includes the trustees or their employees, or both, if their duties are principally connected with the trusteeship.

(B) The premium for the policy must be paid from funds contributed by the employer or employers of the insured persons, by the union or unions or similar employee organizations, or by both, or from funds contributed by the insured persons or from both the insured persons and one (1) or more employers, unions, or similar employee organizations. Except as provided in clause (C), a policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons, except those who reject the coverage in writing.

(C) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(5) A policy issued to an association or to a trust or to one (1) or more trustees of a fund established, created, or maintained for the benefit of members of one (1) or more associations. The association or associations must have at the outset a minimum of one hundred (100) persons, must have been organized and maintained in good faith for purposes other than that of obtaining

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insurance, must have been in active existence for at least one (1) year, and must have a constitution and bylaws that provide that the association or associations hold regular meetings not less than annually to further purposes of the members, that, except for credit unions, the association or associations collect dues or solicit contributions from members, and that the members have voting privileges and representation on the governing board and committees. The policy must be subject to the following requirements:

(A) The policy may insure members or employees of the association or associations, employees of members, one (1) or more of the preceding, or all of any class or classes of members, employees, or employees of members for the benefit of persons other than the employee's employer.

(B) The premium for the policy must be paid from funds contributed by the association or associations, by employer members, or by both, from funds contributed by the covered persons, or from both the covered persons and the association, associations, or employer members.

(C) Except as provided in clause (D), a policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for the insurance must insure all eligible persons, except those who reject such coverage in writing.

(D) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(6) A policy issued to a credit union, or to one (1) or more trustees or an agent designated by two (2) or more credit unions (which credit union, trustee, trustees, or agent must be deemed the policyholder) to insure members of the credit union or credit unions for the benefit of persons other than the credit union or credit unions, trustee, trustees, or agent, or any of their officials, subject to the following requirements:

(A) The members eligible for insurance must be all of the members of the credit union or credit unions, or all of any class or classes of members.

(B) The premium for the policy shall be paid by the policyholder from the credit union's funds and, except as provided in clause (C), must insure all eligible members.

(C) An insurer may exclude or limit the coverage on any member as to whom evidence of individual insurability is not

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satisfactory to the insurer.

(7) A policy issued to cover persons in a group specifically described by another law of Indiana as a group that may be covered for group life insurance. The provisions of the group life insurance law relating to eligibility and evidence of insurability apply to a group health policy to which this subdivision applies.

(8) A policy issued to a trustee or agent designated by two (2) or more small employers (as defined in IC 27-8-15-14) as determined by the commissioner under rules adopted under IC 4-22-2.

SECTION 22. IC 27-8-5-17 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 17. (a) A group accident and sickness insurance policy shall not be delivered or issued for delivery in Indiana to a group that is not described in section 16(1)(A), 16(2)(A), 16(3)(A), 16(4)(A), 16(5)(A), 16(6)(A), ~~or~~ 16(7), **or 16(8)** of this chapter unless the commissioner finds that:

(1) the issuance of the policy is not contrary to the best interest of the public;

(2) the issuance of the policy would result in economies of acquisition or administration; and

(3) the benefits of the policy are reasonable in relation to the premiums charged.

(b) Except as otherwise provided in this chapter, an insurer may exclude or limit the coverage under a policy described in subsection (a) on any person as to whom evidence of individual insurability is not satisfactory to the insurer.".

Page 33, delete lines 36 through 39.

Page 35, between lines 28 and 29, begin a new paragraph and insert:

"SECTION 29. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "small employer" means any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on at least fifty percent (50%) of the working days of the employer during the preceding calendar year, employed at least two (2) but not more than fifty (50) eligible employees, the majority of whom work in Indiana. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.**

(b) The commissioner of the department of insurance and the office of the secretary of family and social services shall, not later than January 1, 2008, implement a program to allow two (2) or more small employers to join together to purchase health

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insurance, as described in IC 27-8-5-16(8), as amended by this act.

(c) The commissioner shall adopt rules under IC 4-22-2 necessary to implement this SECTION.".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass and be reassigned to the Senate Committee on Appropriations.

(Reference is to SB 503 as introduced.)

MILLER, Chairperson

Committee Vote: Yeas 9, Nays 0.

SENATE MOTION

Madam President: I move that Senator Riegsecker be added as coauthor of Senate Bill 503.

MILLER

COMMITTEE REPORT

Madam President: The Senate Committee on Appropriations, to which was referred Senate Bill No. 503, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 9, line 22, strike "subsection" and insert "**section**".

Page 13, line 8, delete "IC 12-15-20-2(7) and insert "**IC 12-15-20-2(8)**".

Page 13, line 13, delete "do" and insert "**does**".

Page 13, line 18, delete "paid claims and Medicaid" and insert "**fee for service and**".

Page 13, line 19, after "care" insert "**paid**".

Page 13, line 29, after "for" insert "**Medicaid**".

Page 13, line 30, delete "under IC 12-15-19-2.1".

Page 13, line 41, delete "extent that" and insert "**availability of**".

Page 13, line 42, delete "are available".

Page 14, line 1, delete "is" and insert "**being**".

Page 14, line 3, delete "limit provided" and insert "**limit, as defined**".

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Page 14, line 4, delete "1396r-4" and insert "**1396r-4,**".

Page 14, line 4, delete "payments are" and insert "**payment is**".

Page 14, line 29, delete "dollars." and insert "**matching funds.**".

Page 14, line 33, delete "reimbursement and" and insert "**reimbursement, including**".

Page 15, line 11, after "hospital's" insert "**in-state**".

Page 15, line 12, delete "paid claims and Medicaid" and insert "**fee for service and**".

Page 15, line 12, after "care" insert "**paid**".

Page 15, line 13, delete "current".

Page 15, line 13, delete "year," and insert "**year referenced in STEP ONE,**".

Page 27, line 11, delete "(before its repeal)".

Page 29, line 31, delete "IC 12-15-20-2(8)(G)." and insert "**IC 12-15-20-2(8)(G)(1).**".

Page 32, between lines 41 and 42, begin a new paragraph and insert:

"**(e) An employer may not contribute more than fifty percent (50%) of the individual's required share to the health care account.**".

Page 35, line 22, after "state" insert "**for deposit in the healthier Indiana insurance fund**".

Page 36, line 4, after "revenues" insert "**and tobacco products tax revenues**".

Page 36, delete lines 10 through 14.

Page 36, line 15, delete "(f)" and insert "**(e)**".

Page 36, line 18, delete "(g)" and insert "**(f)**".

Page 36, line 20, delete "(h)" and insert "**(g)**".

Page 36, delete lines 22 through 30, begin a new paragraph and insert:

"**Sec. 15. (a) The office may not:**

(1) enroll applicants;

(2) approve any contracts with vendors to provide services or administer the program;

(3) incur costs other than those necessary to study and plan for the implementation of the program; or

(4) create financial obligations for the state;

unless both of the conditions of subsection (b) are satisfied.

(b) The office may not take any action described in subsection (a) unless:

(1) there is a specific appropriation from the general assembly to implement the program; and

(2) after review by the budget committee, the budget agency

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approves an actuarial analysis that demonstrates sufficient funding is reasonably estimated to be available to operate the program for at least the following eight (8) years.

The actuarial analysis under subdivision (2) must clearly indicate the cost and revenue assumptions used in reaching the determination.".

Page 36, line 31, delete "(b)" and insert "**(c)**".

Page 36, line 34, delete "(c)" and insert "**(d)**".

Page 38, line 37, delete "year multiplied by" and insert "**year.**".

Page 38, delete lines 38 through 41.

Page 47, delete lines 2 through 5.

Page 47, line 6, delete "(2)" and insert "**(1)**".

Page 47, line 7, delete "(3)" and insert "**(2)**".

Page 47, line 12, delete "(b)(1), (b)(2), or (b)(3)" and insert "**(b)(1) or (b)(2)**".

and when so amended that said bill do pass.

(Reference is to SB 503 as printed February 9, 2007.)

MEEKS, Chairperson

Committee Vote: Yeas 10, Nays 1.

SENATE MOTION

Madam President: I move that Senate Bill 503 be amended to read as follows:

Page 35, line 27, after "insurance" insert "**trust**".

Page 35, line 32, after "insurance" insert "**trust**".

Page 36, between lines 21 and 22, begin a new paragraph and insert:

"**(h) The fund is considered a trust fund for purposes of IC 4-9.1-1-7. Money may not be transferred, assigned, or otherwise removed from the fund by the state board of finance, the budget agency, or any other state agency.**".

(Reference is to SB 503 as printed February 16, 2007.)

MILLER

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COMMITTEE REPORT

Mr. Speaker: Your Committee on Public Health, to which was referred Senate Bill 503, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Delete the title and insert the following:

A BILL FOR AN ACT to amend the Indiana Code concerning coverage of health care and to make an appropriation.

Page 5, between lines 15 and 16, begin a new paragraph and insert:

"SECTION 2. IC 5-10-8-2.2, AS AMENDED BY P.L.2-2005, SECTION 15, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2.2. (a) As used in this section, "dependent" means a natural child, stepchild, or adopted child of a public safety employee who:

(1) is less than eighteen (18) years of age;

(2) is eighteen (18) years of age or older and physically or mentally disabled (using disability guidelines established by the Social Security Administration); or

(3) is at least eighteen (18) and less than twenty-three (23) years of age and is enrolled in and regularly attending a secondary school or is a full-time student at an accredited college or university.

(b) As used in this section, "public safety employee" means a full-time firefighter, police officer, county police officer, or sheriff.

(c) This section applies only to local unit public employers and their public safety employees.

(d) A local unit public employer may provide programs of group health insurance for its active and retired public safety employees through one (1) of the following methods:

(1) By purchasing policies of group insurance.

(2) By establishing self-insurance programs.

(3) By electing to participate in the local unit group of local units that offer the state employee health plan under section 6.6 of this chapter.

(4) By electing to participate in a state employee health plan under section 6.7 of this chapter.

A local unit public employer may provide programs of group insurance other than group health insurance for the local unit public employer's active and retired public safety employees by purchasing policies of group insurance and by establishing self-insurance programs. However, the establishment of a self-insurance program is subject to the approval of the unit's fiscal body.

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(e) A local unit public employer may pay a part of the cost of group insurance for its active and retired public safety employees. However, a local unit public employer that provides group life insurance for its active and retired public safety employees shall pay a part of the cost of that insurance.

(f) A local unit public employer may not cancel an insurance contract under this section during the policy term of the contract.

(g) After June 30, 1989, a local unit public employer that provides a group health insurance program for its active public safety employees shall also provide a group health insurance program to the following persons:

(1) Retired public safety employees.

(2) Public safety employees who are receiving disability benefits under IC 36-8-6, IC 36-8-7, IC 36-8-7.5, IC 36-8-8, or IC 36-8-10.

(3) Surviving spouses and dependents of public safety employees who die while in active service or after retirement.

(h) A retired or disabled public safety employee who is eligible for group health insurance coverage under subsection (g)(1) or (g)(2):

(1) may elect to have the person's spouse, dependents, or spouse and dependents covered under the group health insurance program at the time the person retires or becomes disabled;

(2) must file a written request for insurance coverage with the employer within ninety (90) days after the person retires or begins receiving disability benefits; and

(3) must pay an amount equal to the total of the employer's and the employee's premiums for the group health insurance for an active public safety employee (however, the employer may elect to pay any part of the person's premiums).

(i) Except as provided in IC 36-8-6-9.7(f), IC 36-8-6-10.1(h), IC 36-8-7-12.3(g), IC 36-8-7-12.4(j), IC 36-8-7.5-13.7(h), IC 36-8-7.5-14.1(i), IC 36-8-8-13.9(d), IC 36-8-8-14.1(h), and IC 36-8-10-16.5 for a surviving spouse or dependent of a public safety employee who dies in the line of duty, a surviving spouse or dependent who is eligible for group health insurance under subsection (g)(3):

(1) may elect to continue coverage under the group health insurance program after the death of the public safety employee;

(2) must file a written request for insurance coverage with the employer within ninety (90) days after the death of the public safety employee; and

(3) must pay the amount that the public safety employee would have been required to pay under this section for coverage selected by the surviving spouse or dependent (however, the employer may

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elect to pay any part of the surviving spouse's or dependents' premiums).

(j) A retired or disabled public safety employee's eligibility for group health insurance under this section ends on the earlier of the following:

(1) When the public safety employee becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.

(2) When the employer terminates the health insurance program for active public safety employees.

(k) A surviving spouse's eligibility for group health insurance under this section ends on the earliest of the following:

(1) When the surviving spouse becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.

(2) When the unit providing the insurance terminates the health insurance program for active public safety employees.

(3) The date of the surviving spouse's remarriage.

(4) When health insurance becomes available to the surviving spouse through employment.

(l) A dependent's eligibility for group health insurance under this section ends on the earliest of the following:

(1) When the dependent becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.

(2) When the unit providing the insurance terminates the health insurance program for active public safety employees.

(3) When the dependent no longer meets the criteria set forth in subsection (a).

(4) When health insurance becomes available to the dependent through employment.

(m) A public safety employee who is on leave without pay is entitled to participate for ninety (90) days in any group health insurance program maintained by the local unit public employer for active public safety employees if the public safety employee pays an amount equal to the total of the employer's and the employee's premiums for the insurance. However, the employer may pay all or part of the employer's premium for the insurance.

(n) A local unit public employer may provide group health insurance for retired public safety employees or their spouses not covered by subsections (g) through (l) and may provide group health insurance that contains provisions more favorable to retired public safety employees and their spouses than required by subsections (g) through (l). A local unit public employer may provide group health insurance to a public safety employee who is on leave without pay for

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a longer period than required by subsection (m), and may continue to pay all or a part of the employer's premium for the insurance while the employee is on leave without pay.

SECTION 3. IC 5-10-8-2.6, AS AMENDED BY P.L.1-2005, SECTION 76, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2.6. (a) This section applies only to local unit public employers and their employees. This section does not apply to public safety employees, surviving spouses, and dependents covered by section 2.2 of this chapter.

(b) A public employer may provide programs of group insurance for its employees and retired employees. The public employer may, however, exclude part-time employees and persons who provide services to the unit under contract from any group insurance coverage that the public employer provides to the employer's full-time employees. A public employer may provide programs of group health insurance under this section through one (1) of the following methods:

(1) By purchasing policies of group insurance.

(2) By establishing self-insurance programs.

(3) By electing to participate in the local unit group of local units that offer the state employee health plan under section 6.6 of this chapter.

(4) By electing to participate in a state employee health plan under section 6.7 of this chapter.

A public employer may provide programs of group insurance other than group health insurance under this section by purchasing policies of group insurance and by establishing self-insurance programs. However, the establishment of a self-insurance program is subject to the approval of the unit's fiscal body.

(c) A public employer may pay a part of the cost of group insurance, but shall pay a part of the cost of group life insurance for local employees. A public employer may pay, as supplemental wages, an amount equal to the deductible portion of group health insurance as long as payment of the supplemental wages will not result in the payment of the total cost of the insurance by the public employer.

(d) An insurance contract for local employees under this section may not be canceled by the public employer during the policy term of the contract.

(e) After June 30, 1986, a public employer shall provide a group health insurance program under subsection (g) to each retired employee:

(1) whose retirement date is:

(A) after May 31, 1986, for a retired employee who was a

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teacher (as defined in IC 20-18-2-22) for a school corporation; or

(B) after June 30, 1986, for a retired employee not covered by clause (A);

(2) who will have reached fifty-five (55) years of age on or before the employee's retirement date but who will not be eligible on that date for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.;

(3) who will have completed twenty (20) years of creditable employment with a public employer on or before the employee's retirement date, ten (10) years of which must have been completed immediately preceding the retirement date; and

(4) who will have completed at least fifteen (15) years of participation in the retirement plan of which the employee is a member on or before the employee's retirement date.

(f) A group health insurance program required by subsection (e) must be equal in coverage to that offered active employees and must permit the retired employee to participate if the retired employee pays an amount equal to the total of the employer's and the employee's premiums for the group health insurance for an active employee and if the employee, within ninety (90) days after the employee's retirement date files a written request with the employer for insurance coverage. However, the employer may elect to pay any part of the retired employee's premiums.

(g) A retired employee's eligibility to continue insurance under subsection (e) ends when the employee becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq., or when the employer terminates the health insurance program. A retired employee who is eligible for insurance coverage under subsection (e) may elect to have the employee's spouse covered under the health insurance program at the time the employee retires. If a retired employee's spouse pays the amount the retired employee would have been required to pay for coverage selected by the spouse, the spouse's subsequent eligibility to continue insurance under this section is not affected by the death of the retired employee. The surviving spouse's eligibility ends on the earliest of the following:

(1) When the spouse becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.

(2) When the employer terminates the health insurance program.

(3) Two (2) years after the date of the employee's death.

(4) The date of the spouse's remarriage.

(h) This subsection does not apply to an employee who is entitled

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to group insurance coverage under IC 20-28-10-2(b). An employee who is on leave without pay is entitled to participate for ninety (90) days in any group health insurance program maintained by the public employer for active employees if the employee pays an amount equal to the total of the employer's and the employee's premiums for the insurance. However, the employer may pay all or part of the employer's premium for the insurance.

(i) A public employer may provide group health insurance for retired employees or their spouses not covered by subsections (e) through (g) and may provide group health insurance that contains provisions more favorable to retired employees and their spouses than required by subsections (e) through (g). A public employer may provide group health insurance to an employee who is on leave without pay for a longer period than required by subsection (h), and may continue to pay all or a part of the employer's premium for the insurance while the employee is on leave without pay.

SECTION 4. IC 5-10-8-6.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 6.7. (a) As used in this section, "state employee health plan" means:**

(1) a self-insurance program established under section 7(b) of this chapter to provide group health coverage; or

(2) a contract with a prepaid health care delivery plan entered into by the state personnel department under section 7(c) of this chapter.

(b) The state personnel department shall allow a local unit to provide coverage of health care services for employees of the local unit through any state employee health plan available to state employees.

(c) If a local unit provides health coverage for employees or retired employees of the local unit, the local unit may elect to provide the health coverage, and the state personnel department shall allow the local unit to provide the health coverage:

(1) through a state employee health plan as provided in this section; and

(2) as described in section 2.2 or 2.6 of this chapter, whichever is applicable to the employees or retired employees of the local unit for whom health coverage is being provided.

(d) A local unit employee who receives coverage of health care services under a state employee health plan under subsection (c) must:

(1) receive coverage equal to the coverage provided to state

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employees under the state employee health plan; and

(2) be allowed to choose the state employee health plan under which the local unit employee will be covered.

(e) The total premium rate that is charged to a local unit for coverage of an employee of the local unit under a state employee health plan under this section must be the same total premium rate that is charged to the state for the same coverage for an employee of the state.

SECTION 5. IC 5-10-8-6.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 6.8. (a) As used in this section, "small employer" means a private employer, including a nonprofit organization, that employs at least two (2) but not more than fifty (50) full-time employees.**

(b) As used in this section, "state employee health plan" means:

(1) a self-insurance program established under section 7(b) of this chapter to provide group health coverage; or

(2) a contract with a prepaid health care delivery plan entered into by the state personnel department under section 7(c) of this chapter.

(c) The state personnel department shall allow a small employer to provide coverage of health care services for employees of the small employer under any state employee health plan available to state employees.

(d) IC 27-8-15 does not apply to coverage provided to employees of a small employer under this section.

(e) A small employer's employee who receives coverage of health care services under a state employee health plan under subsection (c) must:

(1) receive coverage equal to the coverage provided to state employees under the state employee health plan; and

(2) be allowed to choose the state employee health plan under which the employee will be covered.

(f) The total premium rate that is charged to a small employer for coverage of an employee of the small employer under a state employee health plan under this section must be the same total premium rate that is charged to the state for the same coverage for an employee of the state.

SECTION 6. IC 6-3.1-31 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]:

Chapter 31. Employee Wellness Program Tax Credit

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Sec. 1. As used in this chapter, "pass through entity" means:

(1) a corporation that is exempt from the adjusted gross income tax under IC 6-3-2-2.8(2);

(2) a partnership;

(3) a limited liability company; or

(4) a limited liability partnership.

Sec. 2. As used in this chapter, "state tax liability" means a taxpayer's total tax liability that is incurred under:

(1) IC 6-3-1 through IC 6-3-7 (the adjusted gross income tax);

(2) IC 6-5.5 (the financial institutions tax); and

(3) IC 27-1-18-2 (the insurance premiums tax);

as computed after the application of the credits that under IC 6-3.1-1-2 are to be applied before the credit provided by this chapter.

Sec. 3. As used in this chapter, "taxpayer" means an individual or entity that has any state tax liability.

Sec. 4. As used in this chapter, "wellness program" means a program that rewards:

(1) overweight employees for losing weight and all employees for maintaining a healthy weight; or

(2) employees for not using tobacco.

Sec. 5. A taxpayer is entitled to a credit against the taxpayer's state tax liability for a taxable year in an amount equal to fifty percent (50%) of the costs incurred by the taxpayer during the taxable year for providing a wellness program for the taxpayer's employees during the taxable year.

Sec. 6. If a pass through entity is entitled to a credit under section 5 of this chapter but does not have state tax liability against which the tax credit may be applied, a shareholder, partner, or member of the pass through entity is entitled to a tax credit equal to:

(1) the tax credit determined for the pass through entity for the taxable year; multiplied by

(2) the percentage of the pass through entity's distributive income to which the shareholder, partner, or member is entitled.

Sec. 7. (a) If the credit provided by this chapter exceeds the taxpayer's state tax liability for the taxable year for which the credit is first claimed, the excess may be carried forward to succeeding taxable years and used as a credit against the taxpayer's state tax liability during those taxable years. Each time that the credit is carried forward to a succeeding taxable year, the

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credit is to be reduced by the amount that was used as a credit during the immediately preceding taxable year.

(b) A taxpayer is not entitled to any carryback or refund of any unused credit.

Sec. 8. To receive the credit provided by this chapter, a taxpayer must claim the credit on the taxpayer's state tax return or returns in the manner prescribed by the department. The taxpayer shall submit to the department all information that the department determines is necessary for the calculation of the credit provided by this chapter.".

Page 5, between lines 35 and 36, begin a new paragraph and insert:

"SECTION 8. IC 12-15-2-13 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 13. (a) A pregnant woman:

(1) who is not described in 42 U.S.C. 1396a(a)(10)(A)(i); and

(2) whose family income does not exceed the income level established in subsection (b);

is eligible to receive Medicaid.

(b) A pregnant woman described in this section is eligible to receive Medicaid, subject to subsections (c) and (d) and 42 U.S.C. 1396a et seq., if her family income does not exceed ~~one~~ **two** hundred ~~fifty~~ percent ~~(150%)~~ **(200%)** of the federal income poverty level for the same size family.

(c) Medicaid made available to a pregnant woman described in this section is limited to medical assistance for services related to pregnancy, including prenatal, delivery, and postpartum services, and to other conditions that may complicate pregnancy.

(d) Medicaid is available to a pregnant woman described in this section for the duration of the pregnancy and for the sixty (60) day postpartum period that begins on the last day of the pregnancy, without regard to any change in income of the family of which she is a member during that time.

(e) The office may apply a resource standard in determining the eligibility of a pregnant woman described in this section.

SECTION 9. IC 12-15-2-15.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 15.8. An individual who is less than nineteen (19) years of age and who is eligible for Medicaid under section 14 of this chapter is eligible to receive Medicaid until the earlier of the following:**

(1) The end of a period of twelve (12) consecutive months following a determination of the individual's eligibility for

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Medicaid.

(2) The individual becomes nineteen (19) years of age.

SECTION 10. IC 12-15-12-14.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 14.5. (a) This section applies to a foster care child who is less than eighteen (18) years of age, is not disabled, and is a Medicaid recipient.**

(b) Not later than January 1, 2008, the office shall require a Medicaid recipient described in subsection (a) to enroll in the risk-based managed care program.

(c) The office:

(1) shall apply to the United States Department of Health and Human Services for any approval necessary; and

(2) may adopt rules under IC 4-22-2;

to implement this section.".

Page 28, line 35, delete "(1)", begin a new line triple block indented and insert:

"**(i)**".

Page 28, line 37, delete "(2)", begin a new line triple block indented and insert:

"**(ii)**".

Page 28, line 41, delete "(3)", begin a new line triple block indented and insert:

"**(iii)**".

Page 29, line 3, delete "(4)", begin a new line triple block indented and insert:

"**(iv)**".

Page 29, line 5, delete "(5)", begin a new line triple block indented and insert:

"**(v)**".

Page 29, line 7, delete "(6)", begin a new line triple block indented and insert:

"**(vi)**".

Page 29, line 9, delete "(7)", begin a new line triple block indented and insert:

"**(vii)**".

Page 29, line 10, delete "subdivisions (1) through (6)," and insert "**items (i) through (vi),**".

Page 29, line 33, delete "IC 12-15-20-2(8)(G)(1)." and insert "**IC 12-15-20-2(8)(G)(i).**".

Page 30, line 11, after "1." insert "**(a)**".

Page 30, between lines 21 and 22, begin a new paragraph and insert:

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"**(b) The term includes the following adults who do not live with the child:**

(1) A legal or biological parent who has partial custody or visitation rights for the child.

(2) The spouse of a parent described in subdivision (1) who is living with the parent described in subdivision (1).".

Page 30, line 31, after "program." insert "**The office shall establish standards for consumer protection and appeal procedures that must include the following:**

(1) Quality of care standards.

(2) A uniform process for participants' grievances.

(3) Standardized reporting of provider performance, consumer experience, and cost.".

Page 31, line 7, delete "Disease" and insert "**Comprehensive disease**".

Page 31, line 8, delete "." and insert "**, including case management.**".

Page 31, between lines 9 and 10, begin a new line block indented and insert:

"**(11) Preventive care services.**

(12) Family planning services, including contraceptives and sexually transmitted disease testing, as described in federal Medicaid law.

(13) Hospice services.

(14) Substance abuse services.

(e) Mental health care services must include:

(1) full access to inpatient services and mental health drugs; and

(2) at least twelve (12) counseling visits and six (6) physician visits.

(f) The program must offer dental and vision services to individuals who pay an additional contribution as determined by the office but not to exceed five percent (5%) of the individual's income. The program must pay at least fifty percent (50%) of the cost of services but not to exceed the existing Medicaid rate for similar services.

(g) The program must comply with any health care coverage requirements required for an accident and sickness policy issued in the state. The program may not permit treatment limitations or financial requirements on the coverage of services for a mental illness or substance abuse if similar limitations or requirements are not imposed on the coverage of services for other medical or

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surgical conditions.".

Page 31, line 16, delete ":".

Page 31, line 17, delete "(A)".

Page 31, run in lines 16 through 17.

Page 31, line 18, delete "if the individual is a custodial" and insert "**.**".

Page 31, delete lines 19 through 22.

Page 31, between lines 33 and 34, begin a new paragraph and insert:

"**(c) An individual's participation in the program does not begin until the individual has made the initial contribution to the individual's health care account.**".

Page 31, line 41, delete ":".

Page 31, line 42, delete "(A)".

Page 31, run in lines 41 through 42.

Page 32, line 1, delete "but not more than five percent (5%)" and insert "**but:**

(A) not more than two percent (2%) if the individual has an annual household income of not more than one hundred fifty percent (150%) of the federal income poverty level;

(B) not more than three percent (3%) if the individual has an annual household income of more than one hundred fifty percent (150%) of the federal income poverty level but not more than two hundred percent (200%) of the federal income poverty; or".

Page 32, delete line 2.

Page 32, line 3, delete "(B)" and insert "**(C)**".

Page 32, line 9, delete "of five percent (5%) of the" and insert "**required under subsection (a)(2)(A)**".

Page 32, line 10, delete "individual's annual income".

Page 32, line 13, delete "thirty (30)" and insert "**sixty (60)**".

Page 32, line 19, delete "eighteen (18)" and insert "**three (3)**".

Page 32, line 20, delete "(e) An" and insert "**(e) Subject to appeal with the office, an**".

Page 32, line 24, after "account." insert "**An individual is not responsible for payment for emergency services outside of the health care account for a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to:**

(1) place an individual's health in serious jeopardy;

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(2) result in serious impairment to the individual's bodily functions; or

(3) result in serious dysfunction of a bodily organ or part of the individual.".

Page 33, line 37, delete "eighteen (18)" and insert "**three (3)**".

Page 34, line 15, after "individual" insert "**who has not been covered by a health care insurance policy in the previous six (6) months and**".

Page 34, line 18, delete "income" and insert "**income; however, standard underwriting principles must apply;**".

Page 34, line 19, delete "or because a slot is not available for the individual;".

Page 34, between lines 21 and 22, begin a new line block indented and insert:

"**(2) An individual who is not eligible for the program because a slot is not available.**".

Page 34, line 22, delete "(2)" and insert "**(3)**".

Page 34, line 28, delete "twelve (12)" and insert "**six (6)**".

Page 34, between lines 32 and 33, begin a new paragraph and insert:

"**(c) An insurer or a health maintenance organization that has contracted with the office to provide health insurance under the program must incorporate cultural competency standards established by the office. The standards must include standards for non-English speaking, minority, and disabled populations.**".

Page 34, line 38, delete "At" and insert "**For an individual who has renewed their application and been accepted into the program, at**".

Page 34, line 38, after "end" insert "**of**".

Page 34, line 38, after "program" insert "**period, any money that is remaining in the individual's health care account must be used to reduce the individual's contributions for the subsequent program period. However, if the individual did not use the amount required for preventative services, the office's contribution in the account may not be used to reduce the individual's contributions.**

(c) If an individual is no longer eligible for the program or is terminated from the program, the individual may withdraw the money that is remaining in the account that the individual contributed. The office shall determine the amount by prorating the remaining amount in the account with the amount contributed by the individual.".

Page 34, delete lines 39 through 42.

Page 35, delete lines 1 through 17.

Page 35, line 20, delete ":".

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Page 35, delete lines 21 through 25.

Page 35, line 26, delete "(2)".

Page 35, run in lines 20 through 26.

Page 35, line 27, delete "if the" and insert "**.**".

Page 35, delete lines 28 through 31.

Page 35, delete line 42.

Page 36, delete lines 1 through 2.

Page 36, line 3, delete "apart" and insert "**separate**".

Page 37, delete lines 6 through 12, begin a new paragraph and insert:

"**(d) The office of the secretary may refer an individual who:**

(1) has applied for health insurance from the program under section 12(b) of this chapter; and

(2) is at high risk of chronic disease;

to the program administered under IC 27-8-10.1.".

Page 37, between lines 16 and 17, begin a new paragraph and insert:

"**Sec. 17. The office shall promote the program and provide information to potential eligible individuals who live in medically underserved rural areas of the state.**

Sec. 18. The office shall participate in a health information technology program that focuses on ways to reduce medical errors and reduce costs in the program.

Sec. 19. The office may develop a health insurance premium assistance program for individuals who have an annual household income of at least two hundred percent (200%) of the federal income poverty level and are eligible for insurance through the individual's employer but can not afford the health insurance premiums. The program established under this section must contain similar eligibility requirements as the program and include a health savings account as a component. An individual's contribution under this section may not exceed two percent (2%) of the individual's annual income.

Sec. 20. (a) Contingent on approval and funding by the United States Department of Health and Human Services and a sufficient appropriation, the office shall develop a health care account program for individuals who are at least eighteen (18) years of age and have an annual household income of at least two hundred percent (200%) but not more than three hundred percent (300%) of the federal income poverty level.

(b) The office may not implement a program under this section without approval from the general assembly.".

Page 40, between lines 19 and 20, begin a new paragraph and insert:

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"SECTION 29. IC 12-17.6-3-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2. (a) To be eligible to enroll in the program, a child must meet the following requirements:

(1) The child is less than nineteen (19) years of age.

(2) The child is a member of a family with an annual income of:

(A) more than one hundred fifty percent (150%); and

(B) not more than ~~two~~ **three** hundred percent ~~(200%),~~ **(300%);**

of the federal income poverty level.

(3) The child is a resident of Indiana.

(4) The child meets all eligibility requirements under Title XXI of the federal Social Security Act.

(5) The child's family agrees to pay any cost sharing amounts required by the office.

(b) The office may adjust eligibility requirements based on available program resources under rules adopted under IC 4-22-2.

SECTION 30. IC 12-17.6-3-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 3. (a) Subject to subsection (b), a child who is eligible for the program shall receive services from the program until the earlier of the following:

(1) The ~~child becomes financially ineligible.~~ **end of a period of twelve (12) consecutive months following the determination of the child's eligibility for the program.**

(2) The child becomes nineteen (19) years of age.

(b) Subsection (a) applies only if the child and the child's family comply with enrollment requirements.

SECTION 33. IC 16-45-4 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]:

Chapter 4. Rural Health Care Pilot Program Support Fund

Sec. 1. As used in this chapter, "office" means the office of technology established by IC 4-13.1-2-1.

Sec. 2. As used in this chapter, "pilot program" refers to the rural health care pilot program established by the Federal Communications Commission under 47 U.S.C. 254(h)(A)(2) to provide federal funding to support the construction of state or regional broadband networks and the services provided over those networks.

Sec. 3. (a) The rural health care pilot program support fund is established for the purpose of making grants to Indiana health care providers who participate in the pilot program. The fund shall be administered by the office.

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(b) The expenses of administering the fund shall be paid from the money in the fund.

(c) The fund consists of:

(1) money appropriated or otherwise designated or dedicated by the general assembly; and

(2) gifts, grants, and bequests.

(d) Notwithstanding IC 5-13, the treasurer of state shall invest the money in the fund not currently needed to meet the obligations of the fund under IC 5-10.3-5. The treasurer of state may contract with investment management professionals, investment advisers, and legal counsel to assist in the management of the fund and may pay the state expenses incurred under those contracts.

(e) Money in the fund at the end of a state fiscal year does not revert to the state general fund.

Sec. 4. (a) The office must use money in the fund to make grants to health care providers who participate in the pilot program. A health care provider that receives a grant under this chapter must use the grant money to make the local match required as a condition of the provider's participation in the pilot program.

(b) The office may:

(1) prescribe grant application forms;

(2) establish grant application procedures; and

(3) take any other action necessary to implement this chapter.

SECTION 34. IC 16-18-2-163 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 163. (a) "Health care provider", for purposes of IC 16-21 and IC 16-41, means any of the following:

(1) An individual, a partnership, a corporation, a professional corporation, a facility, or an institution licensed or legally authorized by this state to provide health care or professional services as a licensed physician, a psychiatric hospital, a hospital, a health facility, an emergency ambulance service (IC 16-31-3), a dentist, a registered or licensed practical nurse, a midwife, an optometrist, a pharmacist, a podiatrist, a chiropractor, a physical therapist, a respiratory care practitioner, an occupational therapist, a psychologist, a paramedic, an emergency medical technician, an emergency medical technician-basic advanced, an emergency medical technician-intermediate, or a person who is an officer, employee, or agent of the individual, partnership, corporation, professional corporation, facility, or institution acting in the course and scope of the person's employment.

(2) A college, university, or junior college that provides health

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care to a student, a faculty member, or an employee, and the governing board or a person who is an officer, employee, or agent of the college, university, or junior college acting in the course and scope of the person's employment.

(3) A blood bank, community mental health center, community mental retardation center, community health center, or migrant health center.

(4) A home health agency (as defined in IC 16-27-1-2).

(5) A health maintenance organization (as defined in IC 27-13-1-19).

(6) A health care organization whose members, shareholders, or partners are health care providers under subdivision (1).

(7) A corporation, partnership, or professional corporation not otherwise qualified under this subsection that:

(A) provides health care as one (1) of the corporation's, partnership's, or professional corporation's functions;

(B) is organized or registered under state law; and

(C) is determined to be eligible for coverage as a health care provider under IC 34-18 for the corporation's, partnership's, or professional corporation's health care function.

Coverage for a health care provider qualified under this subdivision is limited to the health care provider's health care functions and does not extend to other causes of action.

(b) "Health care provider", for purposes of IC 16-35, has the meaning set forth in subsection (a). However, for purposes of IC 16-35, the term also includes a health facility (as defined in section 167 of this chapter).

(c) "Health care provider", for purposes of IC 16-36-5, means an individual licensed or authorized by this state to provide health care or professional services as:

(1) a licensed physician;

(2) a registered nurse;

(3) a licensed practical nurse;

(4) an advanced practice nurse;

(5) a licensed nurse midwife;

(6) a paramedic;

(7) an emergency medical technician;

(8) an emergency medical technician-basic advanced;

(9) an emergency medical technician-intermediate; or

(10) a first responder, as defined under IC 16-18-2-131.

The term includes an individual who is an employee or agent of a health care provider acting in the course and scope of the individual's

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employment.

(d) "Health care provider", for purposes of IC 16-40-4, means any of the following:

(1) An individual, a partnership, a corporation, a professional corporation, a facility, or an institution licensed or authorized by the state to provide health care or professional services as a licensed physician, a psychiatric hospital, a hospital, a health facility, an emergency ambulance service (IC 16-31-3), an ambulatory outpatient surgical center, a dentist, an optometrist, a pharmacist, a podiatrist, a chiropractor, a psychologist, or a person who is an officer, employee, or agent of the individual, partnership, corporation, professional corporation, facility, or institution acting in the course and scope of the person's employment.

(2) A blood bank, laboratory, community mental health center, community mental retardation center, community health center, or migrant health center.

(3) A home health agency (as defined in IC 16-27-1-2).

(4) A health maintenance organization (as defined in IC 27-13-1-19).

(5) A health care organization whose members, shareholders, or partners are health care providers under subdivision (1).

(6) A corporation, partnership, or professional corporation not otherwise specified in this subsection that:

(A) provides health care as one (1) of the corporation's, partnership's, or professional corporation's functions;

(B) is organized or registered under state law; and

(C) is determined to be eligible for coverage as a health care provider under IC 34-18 for the corporation's, partnership's, or professional corporation's health care function.

(7) A person that is designated to maintain the records of a person described in subdivisions (1) through (6).

(e) "Health care provider", for purposes of IC 16-45-4, has the meaning set forth in 47 CFR 54.601(a).

SECTION 35. IC 20-26-5-4, AS AMENDED BY P.L.168-2006, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 4. In carrying out the school purposes of a school corporation, the governing body acting on the school corporation's behalf has the following specific powers:

(1) In the name of the school corporation, to sue and be sued and to enter into contracts in matters permitted by applicable law.

(2) To take charge of, manage, and conduct the educational affairs

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of the school corporation and to establish, locate, and provide the necessary schools, school libraries, other libraries where permitted by law, other buildings, facilities, property, and equipment.

(3) To appropriate from the school corporation's general fund an amount, not to exceed the greater of three thousand dollars ($3,000) per budget year or one dollar ($1) per pupil, not to exceed twelve thousand five hundred dollars ($12,500), based on the school corporation's previous year's ADM, to promote the best interests of the school corporation through:

(A) the purchase of meals, decorations, memorabilia, or awards;

(B) provision for expenses incurred in interviewing job applicants; or

(C) developing relations with other governmental units.

(4) To:

(A) Acquire, construct, erect, maintain, hold, and contract for construction, erection, or maintenance of real estate, real estate improvements, or an interest in real estate or real estate improvements, as the governing body considers necessary for school purposes, including buildings, parts of buildings, additions to buildings, rooms, gymnasiums, auditoriums, playgrounds, playing and athletic fields, facilities for physical training, buildings for administrative, office, warehouse, repair activities, or housing school owned buses, landscaping, walks, drives, parking areas, roadways, easements and facilities for power, sewer, water, roadway, access, storm and surface water, drinking water, gas, electricity, other utilities and similar purposes, by purchase, either outright for cash (or under conditional sales or purchase money contracts providing for a retention of a security interest by the seller until payment is made or by notes where the contract, security retention, or note is permitted by applicable law), by exchange, by gift, by devise, by eminent domain, by lease with or without option to purchase, or by lease under IC 20-47-2, IC 20-47-3, or IC 20-47-5.

(B) Repair, remodel, remove, or demolish, or to contract for the repair, remodeling, removal, or demolition of the real estate, real estate improvements, or interest in the real estate or real estate improvements, as the governing body considers necessary for school purposes.

(C) Provide for conservation measures through utility

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efficiency programs or under a guaranteed savings contract as described in IC 36-1-12.5.

(5) To acquire personal property or an interest in personal property as the governing body considers necessary for school purposes, including buses, motor vehicles, equipment, apparatus, appliances, books, furniture, and supplies, either by cash purchase or under conditional sales or purchase money contracts providing for a security interest by the seller until payment is made or by notes where the contract, security, retention, or note is permitted by applicable law, by gift, by devise, by loan, or by lease with or without option to purchase and to repair, remodel, remove, relocate, and demolish the personal property. All purchases and contracts specified under the powers authorized under subdivision (4) and this subdivision are subject solely to applicable law relating to purchases and contracting by municipal corporations in general and to the supervisory control of state agencies as provided in section 6 of this chapter.

(6) To sell or exchange real or personal property or interest in real or personal property that, in the opinion of the governing body, is not necessary for school purposes, in accordance with IC 20-26-7, to demolish or otherwise dispose of the property if, in the opinion of the governing body, the property is not necessary for school purposes and is worthless, and to pay the expenses for the demolition or disposition.

(7) To lease any school property for a rental that the governing body considers reasonable or to permit the free use of school property for:

(A) civic or public purposes; or

(B) the operation of a school age child care program for children who are at least five (5) years of age and less than fifteen (15) years of age that operates before or after the school day, or both, and during periods when school is not in session;

if the property is not needed for school purposes. Under this subdivision, the governing body may enter into a long term lease with a nonprofit corporation, community service organization, or other governmental entity, if the corporation, organization, or other governmental entity will use the property to be leased for civic or public purposes or for a school age child care program. However, if payment for the property subject to a long term lease is made from money in the school corporation's debt service fund, all proceeds from the long term lease must be deposited in the school corporation's debt service fund so long as payment for the

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property has not been made. The governing body may, at the governing body's option, use the procedure specified in IC 36-1-11-10 in leasing property under this subdivision.

(8) To:

(A) Employ, contract for, and discharge superintendents, supervisors, principals, teachers, librarians, athletic coaches (whether or not they are otherwise employed by the school corporation and whether or not they are licensed under IC 20-28-5), business managers, superintendents of buildings and grounds, janitors, engineers, architects, physicians, dentists, nurses, accountants, teacher aides performing noninstructional duties, educational and other professional consultants, data processing and computer service for school purposes, including the making of schedules, the keeping and analyzing of grades and other student data, the keeping and preparing of warrants, payroll, and similar data where approved by the state board of accounts as provided below, and other personnel or services as the governing body considers necessary for school purposes.

(B) Fix and pay the salaries and compensation of persons and services described in this subdivision.

(C) Classify persons or services described in this subdivision and to adopt schedules of salaries or compensation.

(D) Determine the number of the persons or the amount of the services employed or contracted for as provided in this subdivision.

(E) Determine the nature and extent of the duties of the persons described in this subdivision.

The compensation, terms of employment, and discharge of teachers are, however, subject to and governed by the laws relating to employment, contracting, compensation, and discharge of teachers. The compensation, terms of employment, and discharge of bus drivers are subject to and governed by laws relating to employment, contracting, compensation, and discharge of bus drivers. The forms and procedures relating to the use of computer and data processing equipment in handling the financial affairs of the school corporation must be submitted to the state board of accounts for approval so that the services are used by the school corporation when the governing body determines that it is in the best interest of the school corporation while at the same time providing reasonable accountability for the funds expended.

(9) Notwithstanding the appropriation limitation in subdivision

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(3), when the governing body by resolution considers a trip by an employee of the school corporation or by a member of the governing body to be in the interest of the school corporation, including attending meetings, conferences, or examining equipment, buildings, and installation in other areas, to permit the employee to be absent in connection with the trip without any loss in pay and to reimburse the employee or the member the employee's or member's reasonable lodging and meal expenses and necessary transportation expenses. To pay teaching personnel for time spent in sponsoring and working with school related trips or activities.

(10) To transport children to and from school, when in the opinion of the governing body the transportation is necessary, including considerations for the safety of the children and without regard to the distance the children live from the school. The transportation must be otherwise in accordance with applicable law.

(11) To provide a lunch program for a part or all of the students attending the schools of the school corporation, including the establishment of kitchens, kitchen facilities, kitchen equipment, lunch rooms, the hiring of the necessary personnel to operate the lunch program, and the purchase of material and supplies for the lunch program, charging students for the operational costs of the lunch program, fixing the price per meal or per food item. To operate the lunch program as an extracurricular activity, subject to the supervision of the governing body. To participate in a surplus commodity or lunch aid program.

(12) To purchase textbooks, to furnish textbooks without cost or to rent textbooks to students, to participate in a textbook aid program, all in accordance with applicable law.

(13) To accept students transferred from other school corporations and to transfer students to other school corporations in accordance with applicable law.

(14) To make budgets, to appropriate funds, and to disburse the money of the school corporation in accordance with applicable law. To borrow money against current tax collections and otherwise to borrow money, in accordance with IC 20-48-1.

(15) To purchase insurance or to establish and maintain a program of self-insurance relating to the liability of the school corporation or the school corporation's employees in connection with motor vehicles or property and for additional coverage to the extent permitted and in accordance with IC 34-13-3-20. To

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purchase additional insurance or to establish and maintain a program of self-insurance protecting the school corporation and members of the governing body, employees, contractors, or agents of the school corporation from liability, risk, accident, or loss related to school property, school contract, school or school related activity, including the purchase of insurance or the establishment and maintenance of a self-insurance program protecting persons described in this subdivision against false imprisonment, false arrest, libel, or slander for acts committed in the course of the persons' employment, protecting the school corporation for fire and extended coverage and other casualty risks to the extent of replacement cost, loss of use, and other insurable risks relating to property owned, leased, or held by the school corporation. To:

(A) participate in a state employee health plan under IC 5-10-8-6.6;

(B) purchase insurance; ~~or~~

(C) establish and maintain a program of self-insurance; **or**

(D) participate in a state employee health plan under IC 5-10-8-6.7;

to benefit school corporation employees, including accident, sickness, health, or dental coverage, provided that a plan of self-insurance must include an aggregate stop-loss provision.

(16) To make all applications, to enter into all contracts, and to sign all documents necessary for the receipt of aid, money, or property from the state, the federal government, or from any other source.

(17) To defend a member of the governing body or any employee of the school corporation in any suit arising out of the performance of the member's or employee's duties for or employment with, the school corporation, if the governing body by resolution determined that the action was taken in good faith. To save any member or employee harmless from any liability, cost, or damage in connection with the performance, including the payment of legal fees, except where the liability, cost, or damage is predicated on or arises out of the bad faith of the member or employee, or is a claim or judgment based on the member's or employee's malfeasance in office or employment.

(18) To prepare, make, enforce, amend, or repeal rules, regulations, and procedures:

(A) for the government and management of the schools, property, facilities, and activities of the school corporation, the

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school corporation's agents, employees, and pupils and for the operation of the governing body; and

(B) that may be designated by an appropriate title such as "policy handbook", "bylaws", or "rules and regulations".

(19) To ratify and approve any action taken by a member of the governing body, an officer of the governing body, or an employee of the school corporation after the action is taken, if the action could have been approved in advance, and in connection with the action to pay the expense or compensation permitted under IC 20-26-1 through IC 20-26-5, IC 20-26-7, IC 20-40-12, and IC 20-48-1 or any other law.

(20) To exercise any other power and make any expenditure in carrying out the governing body's general powers and purposes provided in this chapter or in carrying out the powers delineated in this section which is reasonable from a business or educational standpoint in carrying out school purposes of the school corporation, including the acquisition of property or the employment or contracting for services, even though the power or expenditure is not specifically set out in this chapter. The specific powers set out in this section do not limit the general grant of powers provided in this chapter except where a limitation is set out in IC 20-26-1 through IC 20-26-5, IC 20-26-7, IC 20-40-12, and IC 20-48-1 by specific language or by reference to other law.

SECTION 36. IC 27-8-5-2, AS AMENDED BY P.L.125-2005, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2. (a) No individual policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless it complies with each of the following:

(1) The entire money and other considerations for the policy are expressed in the policy.

(2) The time at which the insurance takes effect and terminates is expressed in the policy.

(3) The policy purports to insure only one (1) person, except that a policy ~~may~~ **must** insure, originally or by subsequent amendment, upon the application of any member of a family who shall be deemed the policyholder and who is at least eighteen (18) years of age, any two (2) or more eligible members of that family, including husband, wife, dependent children, or any children ~~under a specified age, which shall not exceed nineteen (19)~~ **who are less than twenty-four (24)** years **of age,** and any other person dependent upon the policyholder.

(4) The style, arrangement, and overall appearance of the policy

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give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in lightface type of a style in general use, the size of which shall be uniform and not less than ten point with a lower-case unspaced alphabet length not less than one hundred and twenty point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description if any, and captions and subcaptions).

(5) The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in section 3 of this chapter, are printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "EXCEPTIONS", or "EXCEPTIONS AND REDUCTIONS", provided that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies.

(6) Each such form of the policy, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page of the policy.

(7) The policy contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of or reference to a statement of rates or classification of risks, or short-rate table filed with the commissioner.

(8) If an individual accident and sickness insurance policy or hospital service plan contract or medical service plan contract provides that hospital or medical expense coverage of a dependent child terminates upon attainment of the limiting age for dependent children specified in such policy or contract, the policy or contract must also provide that attainment of such limiting age does not operate to terminate the hospital and medical coverage of such child while the child is and continues to be both:

(A) incapable of self-sustaining employment by reason of mental retardation or mental or physical disability; and

(B) chiefly dependent upon the policyholder for support and maintenance.

Proof of such incapacity and dependency must be furnished to the insurer by the policyholder within thirty-one (31) days of the child's attainment of the limiting age. The insurer may require at

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reasonable intervals during the two (2) years following the child's attainment of the limiting age subsequent proof of the child's disability and dependency. After such two (2) year period, the insurer may require subsequent proof not more than once each year. The foregoing provision shall not require an insurer to insure a dependent who is a mentally retarded or mentally or physically disabled child where such dependent does not satisfy the conditions of the policy provisions as may be stated in the policy or contract required for coverage thereunder to take effect. In any such case the terms of the policy or contract shall apply with regard to the coverage or exclusion from coverage of such dependent. This subsection applies only to policies or contracts delivered or issued for delivery in this state more than one hundred twenty (120) days after August 18, 1969.

(b) If any policy is issued by an insurer domiciled in this state for delivery to a person residing in another state, and if the official having responsibility for the administration of the insurance laws of such other state shall have advised the commissioner that any such policy is not subject to approval or disapproval by such official, the commissioner may by ruling require that such policy meet the standards set forth in subsection (a) and in section 3 of this chapter.

(c) An insurer may issue a policy described in this section in electronic or paper form. However, the insurer shall:

(1) inform the insured that the insured may request the policy in paper form; and

(2) issue the policy in paper form upon the request of the insured.".

Page 45, between lines 23 and 24, begin a new paragraph and insert:

"SECTION 36. IC 27-8-5-28 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 28. A policy of accident and sickness insurance may not be issued, delivered, amended, or renewed unless the policy provides for coverage of a child of the policyholder or certificate holder, upon request of the policyholder or certificate holder, until the date that the child becomes twenty-four (24) years of age.**".

Page 46, between lines 7 and 8, begin a new paragraph and insert:

"SECTION 38. IC 27-13-7-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 3. (a) A contract referred to in section 1 of this chapter must clearly state the following:

(1) The name and address of the health maintenance organization.

(2) Eligibility requirements.

(3) Benefits and services within the service area.

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(4) Emergency care benefits and services.
(5) Any out-of-area benefits and services.
(6) Copayments, deductibles, and other out-of-pocket costs.
(7) Limitations and exclusions.
(8) Enrollee termination provisions.
(9) Any enrollee reinstatement provisions.
(10) Claims procedures.
(11) Enrollee grievance procedures.
(12) Continuation of coverage provisions.
(13) Conversion provisions.
(14) Extension of benefit provisions.
(15) Coordination of benefit provisions.
(16) Any subrogation provisions.
(17) A description of the service area.
(18) The entire contract provisions.
(19) The term of the coverage provided by the contract.
(20) Any right of cancellation of the group or individual contract holder.
(21) Right of renewal provisions.
(22) Provisions regarding reinstatement of a group or an individual contract holder.
(23) Grace period provisions.
(24) A provision on conformity with state law.
(25) A provision or provisions that comply with the:
(A) guaranteed renewability; and
(B) group portability;
requirements of the federal Health Insurance Portability and Accountability Act of 1996 (26 U.S.C. 9801(c)(1)).
(26) That the contract provides, upon request of the subscriber, coverage for a child of the subscriber until the date the child becomes twenty-four (24) years of age.

(b) For purposes of subsection (a), an evidence of coverage which is filed with a contract may be considered part of the contract.

SECTION 39. [EFFECTIVE JULY 1, 2007] **The state personnel department shall implement the requirements of IC 5-10-8-6.7 and IC 5-10-8-6.8, both as added by this act, not later than July 1, 2008.**

SECTION 40. [EFFECTIVE JULY 1, 2007] **IC 6-3.1-31, as added by this act, applies to taxable years beginning after December 31, 2007.**

SECTION 41. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.**

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(b) The office shall apply to the United States Department of Health and Human Services for any amendment to the state Medicaid plan or demonstration waiver that is needed to do the following:

(1) Implement IC 12-17.6-3-2 and IC 12-15-2-13, both as amended by this act.

(2) Provide for presumptive eligibility for a pregnant woman described in IC 12-15-2-13, as amended by this act.

(c) The office may not implement the amendment or waiver until the office files an affidavit with the governor attesting that the amendment or waiver applied for under this SECTION is in effect. The office shall file the affidavit under this subsection not more than five (5) days after the office is notified that the amendment or waiver is approved.

(d) If the office receives approval for the amendment or waiver under this SECTION from the United States Department of Health and Human Services and the governor receives the affidavit filed under subsection (c), the office shall implement the amendment or waiver not more than sixty (60) days after the governor receives the affidavit.

(e) The office may adopt rules under IC 4-22-2 to implement this SECTION.

SECTION 42. [EFFECTIVE JULY 1, 2007] **(a) IC 27-8-5-2, as amended by this act, and IC 27-8-5-28, as added by this act, apply to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2007.**

(b) IC 27-13-7-3, as amended by this act, applies to a health maintenance organization contract that is entered into, delivered, amended, or renewed after June 30, 2007.

SECTION 43. [EFFECTIVE JULY 1, 2007] **(a) There is appropriated to the office of Medicaid policy and planning from the healthier Indiana insurance trust fund (as established by IC 12-15-44-14, as added by this act) fifteen million dollars ($15,000,000) for the period beginning July 1, 2007, and ending June 30, 2009, to provide funding to increase reimbursement rates under the state Medicaid program (IC 12-15) and the children's health insurance program (IC 12-17.6) for services provided by primary care physicians who are licensed under IC 25-22.5.**

(b) There is appropriated to the rural health care pilot program support fund (as established by IC 16-45-4-3, as added by this act) from the healthier Indiana insurance trust fund (as established by IC 12-15-44-14, as added by this act) two hundred fifty thousand

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dollars ($250,000) for the period beginning July 1, 2007, and ending June 30, 2009, to provide funding for the purpose of making grants to Indiana health care providers who participate in the rural health care pilot program.

(c) This SECTION expires July 1, 2009.

SECTION 44. [EFFECTIVE JULY 1, 2007] **(a) The definitions under IC 12-15-44 apply to this SECTION.**

(b) As used in this SECTION, "task force" refers to the healthier Indiana insurance program task force established by subsection (c).

(c) The healthier Indiana insurance program task force is established to:

(1) study, monitor, provide guidance, and make recommendations to the state concerning the healthier Indiana insurance program;

(2) develop methods to increase availability of affordable coverage for health care services for all Indiana residents;

(3) develop an education and orientation program for individuals participating in the program; and

(4) make recommendations to the legislative council.

(d) The task force:

(1) shall operate under the policies governing study committees adopted by the legislative council; and

(2) may request funding from the legislative council to hire consultants.

(e) The affirmative votes of a majority of the voting members appointed to the task force are required for the task force to take action on any measure, including final reports.

(f) The office shall provide administrative assistance to and staff the task force.

(g) The task force consists of the following voting members:

(1) Eleven (11) members appointed by the speaker of the house of representatives, three (3) of whom are appointed based on the recommendation of the minority leader of the house of representatives and none of whom are legislators.

(2) Eleven (11) members appointed by the president pro tempore of the senate, three (3) of whom are appointed based on the recommendation of the minority leader of the senate and none of whom are legislators.

(h) In making appointments under subsection (g), the speaker of the house of representatives shall appoint members representing the interests listed in subdivisions (1) through (5) and the president

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pro tempore of the senate shall each appoint members representing the interests listed in subdivisions (6) through (11) as follows:

(1) Hospitals.

(2) Insurance companies.

(3) Primary care providers.

(4) Health professionals who are not primary care providers.

(5) Minority health concern experts.

(6) Business.

(7) Organized labor.

(8) Consumers.

(9) Children's health issues.

(10) Adult health issues.

(11) Health marketing and public relations.

(i) The chairman of the legislative council shall appoint the chairperson of the task force.

(j) The task force shall report findings and make recommendations in a final report to the legislative council in an electronic format under IC 5-14-6 before November 1, 2008.

(k) The task force expires November 1, 2008, unless the legislative council extends the work of the task force until November 1, 2009. If the legislative council extends the work of the task force until November 1, 2009, the task force shall submit additional findings and recommendations in a final report before November 1, 2009.

(l) The task force members are not eligible for per diem reimbursement or reimbursement for expenses incurred for travel to and from task force meetings.

(m) This SECTION expires January 1, 2010.".

Page 46, line 20, delete ":".

Page 46, line 21, delete "(A)".

Page 46, run in lines 20 through 21.

Page 46, line 22, delete "if the individual is a custodial" and insert "**.**".

Page 46, delete lines 23 through 26.

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to SB 503 as reprinted February 20, 2007.)

BROWN C, Chair

Committee Vote: yeas 11, nays 1.

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